State of West Virginia

Offices of the Insurance Commissioner

Health Benefit Exchange

Business Plan

Version 1.2

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WEST VIRGINIA OFFICES OF THE INSURANCE COMMISSIONER

Health Benefit Exchange
Business Plan

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Version	Delivered Date	Update Reason
1.0	November 18, 2011	Working Draft
1.1	December 27, 2011	Revised based on OIC comments
1.2	January 19, 2012	Revised based on OIC Comments

Table i: Version History

Prologue

The following document has been produced by the West Virginia Offices of the Insurance Commissioner (OIC). West Virginia continues to assess the feasibility of developing a state-operated Health Benefit Exchange. This is an iterative document and requires periodic updating as more information becomes available. Questions, comments, or concerns related to this document or other Health Benefit Exchange planning efforts should be directed to the West Virginia Offices of the Insurance Commissioner through Jeremiah Samples at Jeremiah.Samples@wvinsurance.gov.

1.0 Executive Summary

The purpose of this Business Plan is to describe the approach to establish and commence operations of West Virginia's Health Benefit Exchange (HBE, the "Exchange") according to federal and state regulations. Because West Virginia continues to assess the feasibility of developing a state-operated Health Benefit Exchange, it is intended to be an iterative document describing Exchange planning efforts and accomplishments to date, as well as future plans to ensure the successful launch of the Exchange and continuing operations should the state choose to proceed in that direction. As new information is gathered and key decisions are made, the plan will be updated accordingly so that West Virginia state leaders and stakeholders have a current understanding of how the Exchange will fulfill its main purpose, as provided for in West Virginia Senate Bill 408: to facilitate the purchase and sale of qualified health plans in the individual market and to establish a Small Business Health Options Program (SHOP) within the Exchange to assist qualified small employers in enrolling their employees in qualified health plans.

The Affordable Care Act (ACA) requires that all states establish a Health Benefit Exchange no later than January 1, 2014, or the federal government will establish and operate an Exchange for the state[1]. However, development of a Health Benefit Exchange in West Virginia was under consideration prior to passage of the ACA due to the state's participation in the State Health Access Program (SHAP) Grant. Based on preliminary research from the SHAP grant, additional background market and industry research, and strong support for a state-run Exchange provided by West Virginia stakeholders after the ACA was passed, state leaders determined it was in the state's best interest to maintain control of policy decisions, and in March 2011 the West Virginia Legislature passed Senate Bill 408 establishing a Health Benefit Exchange in the state.

Senate Bill 408 establishes the West Virginia Health Benefit Exchange within the Offices of the Insurance Commissioner (OIC) as a governmental entity of the state and provides for a ten-member independent Board comprised of state officials and stakeholders with legislative and emergency rule-making authority to oversee the Exchange.

A proposed mission, vision, and set of guiding principles have been drafted for the Exchange; review and approval will be sought from the Board when members are seated. The proposed mission is: The West Virginia Health Benefit Exchange will maximize the number of insured West Virginians, provide consumers with reliable health insurance information, and promote a competitive marketplace that allows individuals, families, and businesses to choose the health plan that provides them the best value. The proposed vision and guiding principles are included in section 4.0. The core services provided by the Exchange are: functioning as a market organizer of health insurance for consumers; providing a transparent source of simplified health insurance information; streamlining eligibility determination and enrollment for public health insurance, advance payment of premium tax credits, and cost-sharing reductions; simplifying health insurance enrollment and administration for consumers, employers, and carriers; and expanding the size of risk pool for consumers. The state Exchange is uniquely positioned in the marketplace to benefit consumers and employers of West Virginia by offering simplified access to and enrollment in affordable, comprehensive, quality health insurance, and providing access

[1] (ACA Sections 1311, 1321)

to advanced payment of the tax credit for individuals and the small business health care tax credit for small employers.

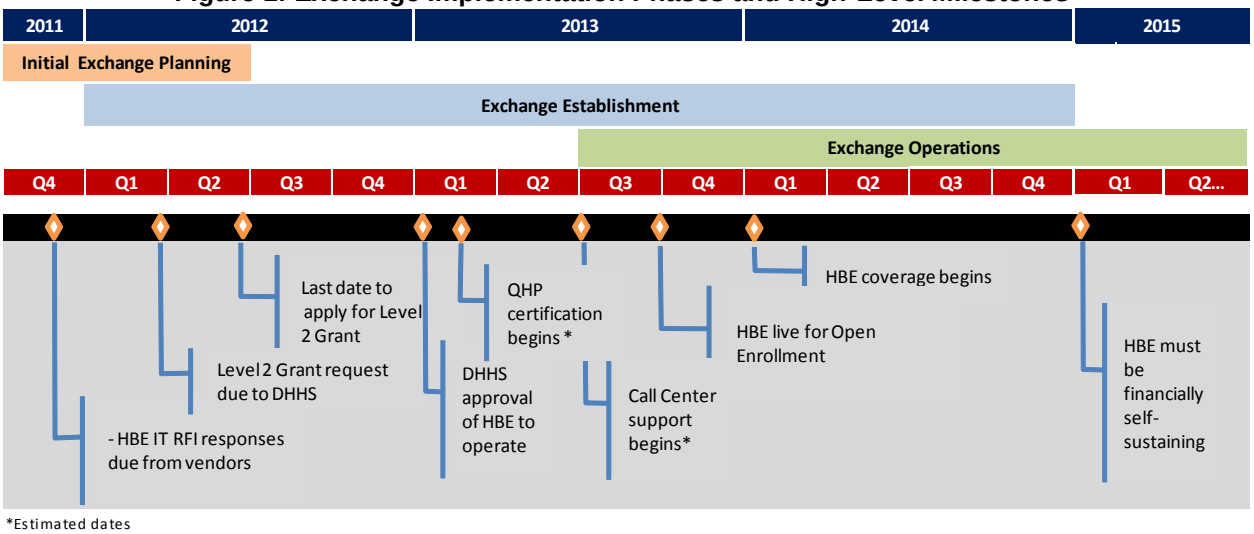
Risks to the development of the Exchange are being addressed using a defined risk management approach as part of the ongoing project management process. The planning team continually monitors known risks and identifies new ones, reviewing and updating them regularly and determining how best to manage them. Sections 6.0 discusses risk mitigation strategies in place, such as a robust communication and outreach plan (Section 7.0). Key project risks include:

- The ability to meet aggressive federally-mandated timelines.
- Poor engagement and participation of key stakeholder groups such as individuals, the business community, producers, and health insurance carriers.
- The possibility that the U.S. Supreme Court will find provisions of the ACA unconstitutional.

Important analyses and information-gathering to guide planning and decision-making, such as an actuarial analysis to project Exchange enrollment and provide other baseline research and economic modeling, are expected to be completed in early 2012. Twelve vendors responded to a request for information (RFI) for Exchange IT components in November 2011, and results are being reviewed, summarized, and mined for key information to assist with Exchange design and cost projections. Exchange planners continue to prepare for the Exchange utilizing business operations based on federal laws, proposed regulations, and guidance, as well as the results of other states' planning efforts and West Virginia's Exchange IT Strategic Plan. An overview of decisions and plans made to date is provided in Section 8.0, Operations Plan, and Section 9.0, Staffing/Resource Plan.

A timeline with the phases of Exchange implementation and high-level milestones is provided below.

Figure 1: Exchange Implementation Phases and High-Level Milestones



Until data from the actuarial analysis is available, Exchange planners are reviewing other states' budget estimates to project costs. Based on publicly available information from five other states,

start-up costs average approximately $50 million, with a range of $22 million in Arizona to $89 million for a robust model in Illinois, largely comprised of IT systems development costs, which average approximately 76 percent of overall expenses in the start-up years. Ongoing costs will depend on factors such as enrollment and Exchange policy, technical, and operational design decisions. Estimated year one operating costs for six states range from one million dollars to over twenty-seven million dollars.

Funding (or revenues) now through 2014 will come from federal Exchange Establishment Grants; the Exchange will allocate costs to Medicaid and the Children's Health Insurance Program (CHIP) based on projected use of Exchange IT services in accordance with federal guidelines. To become financially self-sustaining beginning in January 2015 when Federal grants expire, Senate Bill 408 allows the Board to assess fees on health carriers selling qualified dental or health benefit plans in West Virginia, including health benefit plans sold outside the Exchange, based on premium volume.

2.0 The Business Case

The business case addresses, at a high level, the justification for the Exchange and the business need it seeks to meet. It includes the reasons for its development and implementation and the expected benefits to consumers in the state of West Virginia. The Exchange business case includes federal and West Virginia legislation mandating its establishment, as well as the underlying need for easier access to affordable health insurance for individuals and small businesses in the state to reduce the number of uninsured and underinsured West Virginians and ultimately to create a healthier population. Having accurate information on various aspects of the health insurance market and industry is essential as it serves as the backbone of actuarial models, business and operational plans, education and outreach plans, technological assessment plans, and the development of an overall project strategic plan. This information is also important when educating and discussing policy directions with executive and legislative policymakers, consumer groups, private carriers, producers, and all other interested stakeholder groups.

Known information and existing background research is presented in the first three main sections of the Business Case: Enabling Federal and State Legislation, Market Analysis, and Industry Analysis. In addition, a fourth section highlights information needed to complete the market and industry analysis that will be obtained through planned actuarial analyses. The main sections and sub-sections of the Business case include:

- 2.1 Enabling Federal and State Legislation
  - 2.1.1 Federal Legislation
  - 2.1.2 Stakeholder Support for a West Virginia Exchange
  - 2.1.3 State Legislation
- 2.2 Market Analysis
  - 2.2.1 Uninsured and Underinsured Population
    - Non-Elderly Adults
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    - 3.3.3.3 Accountable Care Organizations
  - 2.3.4 Producers
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2.1 Enabling Federal and State Legislation

2.1.1 Federal Legislation

The Patient Protection and Affordable Care Act, together with the modifications included in the Health Care and Education Reconciliation Act of 2010, are collectively known as the Affordable Care Act (ACA). One of the key reforms resulting from the ACA is the requirement that all states establish a Health Benefit Exchange no later than January 1, 2014, or the federal government will establish and operate an Exchange for the state (ACA Sections 1311, 1321). Exchanges will facilitate the purchase of qualified health plans[2] for individuals and provide for the establishment of a Small Business Health Options Program (SHOP) to assist qualified small employers to enroll their employees in qualified health plans in the small group market. Exchanges are intended to fulfill the need for competitive marketplaces for individuals and small employers to directly compare available private health insurance options on the basis of price, quality, and other factors; Exchanges will enhance competition in the health insurance market, improve choice of affordable health insurance, and give small businesses the same purchasing clout as large businesses (U.S. Department of Health and Human Services [DHHS], 2011).

The law also includes an "individual responsibility" provision (ACA Section 1501), which requires applicable individuals[3] to maintain minimum essential health insurance coverage[4] or else pay a penalty (Section 5000A). In addition, Section 1513 outlines "shared responsibility" for large employers (greater than 50 full-time equivalent employees), assessing penalties on them if minimum essential coverage is not provided and one or more full-time employees enroll for coverage in an Exchange and qualify for a premium tax credit or cost-sharing reduction.

To assist individuals and families in maintaining minimum essential health insurance coverage, the ACA makes new premium tax credits and cost-sharing reductions available to help them afford health insurance purchased exclusively through the Exchange (ACA Sections 1401, 1402). The premium tax credit can be paid in advance and is refundable so taxpayers who have little or no income tax liability can still benefit, and payments equal to the cost-sharing reduction will be paid directly to carriers by the federal government. The ACA also provides for a small business tax credit that helps small businesses and small tax-exempt organizations afford the cost of covering their employees; the credit is specifically targeted for low- and moderate-income workers. Purchasing employer-sponsored coverage through the SHOP will qualify small employers to receive the small business tax credit for up to 50 percent of the employer's premium contributions toward employee coverage (ACA Section 1421). Please see Sections 6.1.1 and 6.1.2 for additional details on the premium tax credit and small business tax credit.

2.1.2 Stakeholder Support for a West Virginia Exchange

Plans for the West Virginia Exchange have progressed more quickly than in many other states due to the state's participation in the State Health Access Program (SHAP) Grant, which was issued by the Health Resources and Services Administration in September 2009. The grant, awarded to thirteen states, was designed to develop a subsidized coverage program for the

[2]Please see section 1301 of the ACA and the U.S. DHHS Notice of Proposed Rulemaking, 45 Part 156, for qualified health plan definition and requirements.

[3]Exceptions to the individual responsibility mandate include individuals with a religious conscience exemption; in a health care sharing ministry; not lawfully present in the U.S.; incarcerated individuals; members of Indian tribes; and individuals who cannot afford coverage.

[4]Includes government-sponsored programs, affordable employer-sponsored plans meeting minimum value, plans in the individual market, grandfathered health plans, and other coverage such as State health benefits risk pools.

working uninsured, provide funding for Health Benefit Exchange research initiatives, and develop a data collection tool to better understand the health status of the uninsured and how they utilize the health care system in the state. Consequently, development of a Health Benefit Exchange in West Virginia was already under consideration prior to passage of the ACA. Additionally, as noted above, had West Virginia decided not to develop and operate its own Exchange, per Section 1321 (c) of the Act the federal government would have established and operated one for the state.

Prior to passing legislation in support of a state-run Exchange, West Virginia state leaders engaged in extensive efforts to maximize public input into whether or not the state should create its own Exchange or, alternatively, allow the federal government to do so for West Virginia. These efforts included holding a series of well-attended public information and engagement meetings across the state, as well as the issuance of a formal request for comment on Exchange-related provisions. Feedback gathered from stakeholders –including consumers, consumer advocates, businesses, members and organizations within the insurance industry, and other state agencies such as the Bureau for Medical Services- made it clear that strong support existed for the development of a West Virginia Exchange to preserve state autonomy and regulatory authority and to best serve the unique needs of the state's individuals, families, and markets.

Results of a questionnaire distributed during the six stakeholder meetings held from November 2010 –January 2011 lend support to the belief that West Virginians prefer a state- versus federally-operated Exchange. Sixty-seven percent of individuals responding to the question "Who should operate West Virginia's Health Insurance Exchange?" indicated the state of West Virginia should. Thirty-one percent indicated a non-profit entity should run the Exchange and only one percent thought the federal government should[5] do so (WV OIC, January 2011).

Additional written feedback received as part of the request for comments includes:

- "…we strongly encourage the State of West Virginia to establish and operate its own exchange. The state could elect not to establish an exchange, but the federal government would then step in and manage the complete operations of the exchange here without consideration for the best interests of West Virginia residents. It is imperative that West Virginia create and maintain its own exchange…." -Independent Insurance Agents of West Virginia
- "The State of West Virginia should establish its own Exchange without the inclusion of other states." -The West Virginia HMO Association
- "The goal of the Exchange should be to facilitate the implementation of PPACA while remaining committed to serving the citizens of West Virginia by meeting the specific and specialized needs of the state's population." -Highmark West Virginia
- "The West Virginia Chamber supports development and expansion of the Small Business Health Options Program (SHOP) Exchange among individuals and small businesses." –West Virginia Chamber of Commerce
- "This is the most transparent public policy I've seen developed at the state level in 30 years." – Perry Bryant, West Virginians for Affordable Health Care

Stakeholders across West Virginia supported a state-run Exchange to ensure the unique needs of West Virginia's consumers, businesses, and health insurance market are met.

[5] One percent had no preference.

2.1.3 State Legislation

Based on months of gathering input from key stakeholders across the state, West Virginia state leaders determined it was in the state's best interest to maintain control of policy decisions made for the Exchange, and in March 2011, the West Virginia Legislature passed Senate Bill 408. The Bill, which was introduced as a modified version of the National Association of Insurance Commissioners' (NAIC) Health Benefit Exchange model, created a new article in the WV Code, 33-16G, to establish a Health Benefit Exchange. This bill authorizes the establishment of the Exchange administratively within the OIC with an autonomous Board. For additional details on the Exchange Board and governance, please see Section 3.0.

2.2 Market Analysis

Exchange consumers will include: uninsured individuals; certain individuals in state programs today (many of whom will have access to subsidized coverage through the Exchange); people who currently purchase individual insurance but who will take advantage of the affordable, comprehensive, quality insurance offered through the Exchange; and people (some insured and others currently uninsured) who work for small employers who choose to use the SHOP Exchange. Planners must understand these target market segments for the Exchange's services in order to optimize its role in facilitating the purchase and sale of health insurance and to maximize the opportunity for individuals to benefit from premium tax credits and cost-sharing reductions and for small businesses to benefit from tax credits. Additionally, the Exchange must become a self-sustaining business after January 2015[6], and because revenues after that time will largely be dependent on enrollment volume, the Exchange must attract and retain an adequate portion of the target market for its services. Although an actuarial analysis to obtain up-to-date, detailed, and comprehensive market information is planned, a review of existing data and reports provides a meaningful baseline upon which Exchange leaders can plan efforts.

2.2.1 Uninsured and Underinsured Population

2.2.1.1 Non-Elderly Adults

Uninsured

The Annual Social and Economic Supplement (ASEC) to the US Census Bureau's Current Population Survey (CPS) indicates that in 2008-2009, 232,400 West Virginians ages 19-64 were uninsured, or approximately 21 percent of individuals in that age group. According to the CPS, although the percentage of individuals covered by employer and individual insurance decreased between 2008-2009, the number of uninsured West Virginians ages 19-64 also decreased, which appears largely to be the result of a 3.1 percent increase in Medicaid coverage (Kaiser Family Foundation [KFF]). See Table 1 below for details. The data on employer-sponsored insurance supports the findings of a 2007 West Virginia Healthcare Survey, which indicated that although the number of employed adults increased by 58,725 to 699,899 in 2007 (compared to 2003), only 459,653 were eligible for employer health insurance, down nearly 50,000 from 2003 (West Virginia University Institute for Health Policy Research, 2008).

Table 1: Percentage Change in Insurance Coverage Among West Virginians Ages 19-64, 2008-2009

Coverage Type	2008-2009 (%)

[6] The ACA requires Exchanges to become self-sufficient after January 1, 2015 [Section 1311(d)(5)(A)]; prior to that time, federal grant funds are available for Exchange establishment and operational expenses.

Employer-Sponsored Insurance	-1.2
Individual Insurance	-0.3
Medicaid	3.1
Other Public (Federal)	0.1
Uninsured	-1.8

Data Source: Kaiser Family Foundation: statehealthfacts.org

Although the information is not as current, findings from surveys completed by the West Virginia University Institute for Health Policy Research (the "Institute") in 2001, 2003, and 2007 provide meaningful insight into the uninsured population in West Virginia. In 2001, the Institute coordinated the first West Virginia Healthcare Survey of 16,493 households to learn about West Virginians who did not have health insurance – who they were, what the circumstances of their lives were, and what relationship the lack of insurance had to their health status and their access to healthcare services. The survey was updated in 2003 and was repeated a third time in 2007 with a sample of 1,750 households, providing statewide measures of change over the years. According to the 2007 survey, on any given day in West Virginia 236,174 non-elderly adults (aged 19-64) were without health insurance, representing 21.5 percent of the non-elderly adult population. Over 60 percent of these uninsured had some connection to work. Many of the working uninsured were employed in seasonal, temporary or part-time jobs that did not offer insurance benefits, or full-time jobs that paid low wages without health coverage. Many worked in small businesses that could not afford to offer comprehensive employer-sponsored health insurance; others had difficulty finding affordable insurance due to the way the insurance marketplace is structured (i.e., largely employment-based) or due to pre-existing medical conditions (West Virginia University Institute for Health Policy Research [WVIHPR], 2008).

The following are key findings from the report developed by the Institute based on the 2007 West Virginia Healthcare Survey (WVIHPR, 2008).

- On any given day in 2007, 236,174 adults aged 19-64 (21.5%) had no health insurance, an increase of 8.3 percent, or 18,241 people, from 2001.
- The number of adults uninsured for part or all of 2007 increased 6.3 percent from 2001, representing 307,478 people, or approximately one out of every 3.6 adults in West Virginia.
- Seventy-five percent of uninsured adults in West Virginia had been without health insurance for a year or longer. The largest increase between 2001 and 2007 was seen in those without insurance for between one and ten years.
- The high cost of premiums, co-payments and deductibles remained the biggest obstacle to obtaining health insurance, and increased as the reason given for lack of coverage compared to the 2001 survey. Lack of employment and lack of employment-based insurance were the second and third reasons provided for being uninsured.
- Between 2001 and 2007, there was a decline in the percent of adults who were self-insured, which may reflect increased costs of health insurance. The biggest percentage increases were for those with Medicaid, Medicare under age 65, and "other" forms of coverage.
- The risk of being uninsured was greatest for younger adults (aged 19-34), and this risk increased for this age group over time. In contrast to the earlier survey, in 2007 males constituted the majority (50.3%) of uninsured adults.
- Regionally, the highest rates of uninsurance occurred in the southern part of the state,

and uninsurance rates increased for all regions except the eastern panhandle.

- Uninsurance was strongly linked to socioeconomic conditions. Persons with less than a high school education, and who were unemployed or employed in low paying jobs, were at substantially greater risk of being uninsured. Seventy-five percent of adults without insurance had a high school education or less. Sixty-five percent of unemployed adults did not have health insurance.
- Almost 19 percent of working adults did not have health insurance. Working adults without health insurance, compared to those with insurance, report poorer health status and fewer visit a healthcare provider.
- Among those who are employed, health insurance was more likely to be offered by large firms and for full-time workers. Persons who enjoyed comprehensive health insurance coverage constitute a smaller percentage of insured persons compared to the 2001 survey, while persons whose coverage was limited to catastrophic care increased as a percent of insured persons.
- The overall profile of a typical person without insurance was a male, aged 19-34, who was unemployed and had a high school education.

The findings from these surveys support the case that individuals and small employers in West Virginia need access to quality, affordable health insurance, a need the Exchange will address.

Underinsured

Uninsured figures are probably a low estimate of potential Exchange consumers as they do not include individuals who are underinsured. Underinsured individuals lack the financial resources to pay for out-of-pocket costs such as premiums and deductibles, and they may have catastrophic-only coverage, exposing them to financial risk and medical debt accumulation. Underinsured individuals also have more limited access to care than adequately insured individuals. A study by the CommonWealth Fund estimated 16 percent of all non-elderly adults were underinsured[7] in 2010. The study found the risk of being underinsured and uninsured is concentrated in populations with incomes below 133 percent and of 133–250 percent of poverty, with these two groups accounting for seven in ten adults who were underinsured or uninsured. The risk, however, is rising up the income scale with 30 percent of adults with annual incomes of 250–399 percent of poverty being underinsured or uninsured. According to the study authors, nearly eight in ten adults with incomes below 133 percent of poverty and three-quarters of those with incomes of 133–249 percent of poverty could gain from reduced premiums, enhanced benefits, and expanded coverage as a result of the ACA provisions. The authors also caution adults with incomes of 250–400 percent of poverty could remain at risk for combined out-of-pocket expenses and premiums that are high relative to their incomes, however, careful benefit design and the choice of plans offered through the Exchange will attenuate that risk (Schoen, C., Collins, S.R., Robertson, R.H., & Doty, M.M., 2010). By facilitating eligibility determination for expanded Medicaid coverage and health insurance premium assistance and cost-sharing, and by enrolling members in either Medicaid or qualified health plans, the Exchange is well-positioned to reduce the problem of the underinsured in West Virginia.

2.2.1.2 Children

Aided by progressive expansion of income limits since program inception and strong outreach and enrollment efforts by the CHIP and Medicaid programs in West Virginia, the percentage of

[7] The definition is based on indicators of cost exposure relative to income.

uninsured children in the state is 4.6 percent (WVCHIP Enrollment Report, 2001). While lower than the national average of 10 percent (KFF, 2009), the opportunity for the Exchange to help close the gap so that all children in West Virginia have access to health coverage and care remains.

2.2.2 Small Employers

The ACA requires states operating an Exchange to also establish a SHOP, enabling small employers to offer affordable health plans to their employees and qualifying certain small employers to receive a small business tax credit for a portion of their premium contributions toward employee coverage. Kaiser estimates that about 47 percent of insured individuals in West Virginia receive their insurance through their employer, which is slightly lower than the national rate of 49 percent.

Early assessments from the federal government estimated that over 22,000 small businesses in West Virginia could benefit from the tax credit. Health Care for America Now reports data from the Robert Wood Johnson Foundation indicating that about 140,000 non-elderly adults in West Virginia hold jobs that don't offer health insurance benefits, comprising just over 60 percent of all non-elderly uninsured people. Recent data shows that about 32 percent of West Virginia businesses with fewer than 50 employees currently offer health insurance to employees, compared to 39 percent of businesses of the same size nationally, and 96 percent of large employers in the state. Nearly 70 percent of the state's private sector establishments have fewer than 50 employees.

2.2.3 Other Public Health Considerations for the Exchange

Population Socioeconomic Factors and Health Statistics

The guiding principles of the Exchange include increasing access to affordable health insurance coverage options with the goal of reducing the number of uninsured and underinsured West Virginians and ultimately improving the health of the population. Numerous studies have shown that socioeconomic factors such as education, income, unemployment, and access to health care influence individuals' physical and mental health status, and chronic disease in particular has been disproportionately associated with these factors (West Virginia Bureau of Public Health, 2011). Chronic disease is also at the center of health care costs nationally and within West Virginia. Although the chronically ill account for less than half the population, care for chronic illness accounts for 78 percent of all health care spending. People with chronic illnesses have total annual yearly medical expenditures that are twice as much as those without such conditions and nationally they account for 76 percent of hospital admissions, 88 percent of prescriptions being filled, and 72 percent of all doctor visits (The Council of State Governments, 2003). Twenty percent of hospital charges in West Virginia are related to diabetes and eight of every 10 hospital discharges are related to cardiovascular disease.

Unfortunately, many West Virginians are impacted both by challenging socioeconomic factors as well as chronic disease. The unemployment rate in West Virginia was eight percent in August 2011 (U.S. Department of Labor), and approximately 20 percent of West Virginians are below the federal poverty level (KFF, 2008-2009). Completion rates for high school and college bachelor's degrees are lower than the national average at 81.6 percent and 17.1 percent, respectively (U.S. Census Bureau). West Virginia also has one of the highest percentages (17%) of its total population over age 65 (KFF, 2008-2009). In 2010, West Virginia ranked highest nationally in the rate of tobacco use (26.8%); second highest for physical inactivity

(32.9%), heart disease (6%), heart attack (6.3%), and fair or poor self-reported adult health (23.4%); and third for diabetes (12.4%) and overweight and obesity (67.9%) (Centers for Disease Prevention and Control, 2010). All of these factors contribute to a high degree of health disparities and unfavorable outcomes in West Virginia and associated high expenditures on health care services.

The prevalence of chronic conditions is a significant barrier to achieving the intended population health improvement objectives of the ACA and poses a risk to issuers of coverage in the Exchange. The cost of treating and managing these chronic conditions (thereby driving the overall cost of healthcare and the cost of maintaining healthcare coverage) is a key determinant in plan design and sustainability. A strong focus on prevention is essential. Developing methods to ensure consumers have access to the appropriate choices to maximize their health outcomes, and then developing a mechanism to insulate the issuers from poor risk, are essential in Exchange planning efforts.

Behavioral Health

A number of studies show that access to appropriate behavioral health services is an issue for the uninsured. A Kaiser study notes that the chances of having good mental health decline with income: one in seven poor adults has only fair or poor mental health; and the poor are over three times as likely as those with incomes of 200 percent or more of poverty to describe their level of mental health as fair or poor (14% vs. 4%). (Kaiser Commission on Medicaid and the Uninsured, 2009). Beyond having access to behavioral health services through the Exchange, the implications for the Exchange include that efforts must be taken to ensure that individuals with behavioral health issues are capable of using the Exchange, with appropriate assistance in selecting plans that meet the consumer's physical and behavioral health needs.

2.3 Industry Analysis

Understanding the private and publicly-funded sources of health insurance at work in the state, the distribution of their products and services, and basic trends and growth over time within the industry is critical to the success of the Exchange. To become a viable entity, the Exchange must create an attractive marketplace for carriers to sell their products, and producers must be appropriately incentivized to direct consumers to plans offered within the Exchange. In addition, the ACA significantly expands Medicaid coverage and requires states to establish a single, streamlined eligibility and enrollment process that serves as the central point of access for the Exchange, Medicaid, and CHIP, so an understanding of that population's unique needs and the growth expected in it as a result of the expansion is essential for Exchange planning and operations.

2.3.1 Commercial Health Insurance

2.3.1.1 Carriers in the Individual and Group Markets

Health insurance sales in West Virginia are concentrated to a few major private carriers, which may have implications for how the state chooses to operate the Exchange (i.e., will West Virginia adopt an "active purchaser" or an open marketplace model). According to the most recent Accident and Health Insurance Market Report completed in 2008 by the OIC, the state's top five companies for large group sales accounted for nearly 90 percent of covered lives in 2007. The situation was similar for the small group market (the top five companies covered 86 percent of lives; the top two covered 69 percent) and the individual market (the top three companies covered 86 percent of lives). Highmark BlueCross BlueShield West Virginia was the dominant player in the marketplace, covering 45 percent of individuals receiving health

insurance in the commercial group and individual markets. Although the carrier make-up covering the small and large group markets was similar, with the exception of Highmark, the individual market was comprised of a different group of carriers, likely due to the special underwriting and marketing strategies required for that market segment. Please see the following tables for the top 10 carriers in the small group and individual markets.

Table 2: Top 10 Carriers of Small Group Major Medical Coverage

Earned Premium ($)	Company Name	Covered Lives
$162,029,170	Highmark BlueCross BlueShield West Virginia	40,152
$41,868,043	Coventry Health and Life Insurance Company	12,878
$25,376,798	Carelink Health Plans, Inc.	5,490
$13,814,190	UnitedHealthcare Insurance Company	5,083
$9,277, 927	Principal Life Insurance Company	2,367
$8,929,211	The Health Plan of the Upper Valley	2,227
$5,551,64**5**	Union Security Insurance Company	1,106
$5,319,156	First Health Life and Health Insurance Company	1,033
$5,096,802	Consumers Life Insurance Company	1,530
$5,031,363	Medical Benefits Life Insurance Company	1,445
$14,662,570	Others (17)	3,730
$296,956,875	**Totals (27)**	**77,041**

Data Source: West Virginia OIC, Accident and Health Insurance Market Report for 2008, November 2008.

Table 3: Top 10 Carriers of Individual Major Medical Coverage

Earned Premium ($)	Company Name	Covered Lives
$36,437,253	Highmark BlueCross BlueShield West Virginia	8,910
$5,664,108	Time Insurance Company	2,887
$2,779,807	John Alden Life Insurance Company	1,480
$945,894	The Health Plan of the Upper Ohio Valley	264
$658,975	Continental General Insurance Company	86
$330,659	Aetna Life Insurance Company	125
$247,126	American Republic Insurance Company	43
$162,771	Metropolitan Life Insurance Company	148
$117,562	American National Life Insurance Company	30
$107,794	Prudential Insurance Company of America	397
$449,889	Others (28)	1,025
$47,901,838	**Totals (38)**	**15,395**

Data Source: West Virginia OIC, Accident and Health Insurance Market Report for 2008, November 2008.

The report also indicates that the private market for health insurance is "relatively stable by the measures of carrier entry and exit, premium volume, and number of covered lives." According to the report, major medical health insurance resulted in earned premium revenues of $786 million in 2007 and covered approximately 215,166 lives in West Virginia. The OIC reports health insurance sold by commercial providers in the state to large groups (employers with over 50 eligible employees) represents 53 percent of the covered lives, to small groups (employers with two to 50 eligible employees) represents 39 percent of covered lives, and to individuals represents eight percent of covered lives.

2.3.1.2 Private Health Benefit Exchanges

Private health exchanges, such as eHealthInsurance.com, provide a web-based shopping experience for consumers and act as a clearinghouse for health insurance plans in West Virginia. eHealthInsurance.com, the leading online source for health insurance in the U.S., serves as a distribution channel for health plans from carriers such as Highmark, UnitedHealthcare, and Coventry for individuals, families, and small businesses. The company professes to provide consumers with "transparency of information about a broad array of health insurance plans with a selection of price and benefit options" (www.ehealthinsurance.com). Fees are paid to the company by carriers in the form of commissions, which are built into the premium amount. The website claims customers can complete an on-line application and receive and electronic approval in 11 minutes, and customer service support (including license insurance agents) is available via e-mail, fax, live online chat, or a toll-free number 24 hours a day, seven days a week to answer consumer questions "throughout the process of buying and using health insurance" (www.ehealthinsurance.com). To further simplify the shopping experience, eHealthInsurance recently launched a mobile application that allows consumers to shop for health insurance using their smart phones. Although eHealthInsurance advertises over two million insured customers, it is unclear how many West Virginia consumers use the website to purchase individual or group insurance.

Similar to eHealthInsurance, Getinsured.com advertises itself as "a private exchange for comprehensive health insurance research, quotes and support" that advises more than 1 million consumers each year across the United States (www.getinsured.com). Individuals and small businesses may shop and compare plans online, however, they cannot purchase insurance directly from the site (i.e., a broker must contact the consumer). Carrier participation in West Virginia appears more limited than on eHealthInsurance, as are customer service hours.

Numerous other websites offer a range of services related to the purchase of health insurance to West Virginians, however, the services and choices appear more limited. For example, affordable-health-insurance-plans.org allows consumers to enter personal information online, however quotes are not provided to the member until local agents contact the consumer and provide those quotes based on the information provided. Extend Health also calls itself an insurance exchange, offering shop and compare services to individuals and employers, and although it does provide commercial individual health plans, it is largely focused on the Medicare market. On its website, www.extendhealth.com, Extend Health claims it is the "industry's largest private Medicare Exchange and has helped more than 300,000 retirees find and choose the private Medicare plan that best meets their medical needs and budgets."

In November 2011, Highmark, Inc. announced they would “fundamentally change small business health insurance” by partnering with Array Health Solutions to pilot a private health insurance exchange program for small businesses. The plan is designed for employers to offer a monthly fixed-dollar amount for each employee's insurance needs. Employees can then visit an online system to select from seven Highmark health insurance plans and two dental and vision insurance plans. The exchange will be offered to small employer groups covering 10 to 99 people beginning January 1, 2012. The processes of paperwork and fees will be the same as any other Highmark insurance plan.

It is clear that these and other developments in the private exchange market must continue to be monitored and their impact on the West Virginia Exchange assessed to ensure Exchange leaders respond and adjust business strategy accordingly.

2.3.2 Subsidized and State Insurance Programs

Nearly 50 percent of individuals in West Virginia receive their health insurance through a subsidized program or the state-run Public Employees Insurance Agency (PEIA) insurance program. The major programs are described below.

2.3.2.1 Medicaid

The West Virginia Medicaid program is managed by the Bureau for Medical Services (BMS), a bureau within the Department of Health and Human Resources (DHHR). The total Medicaid expenditures for SFY2011 were approximately $2.7 billion. The Medicaid program provides health care benefits to just over 420,000 people annually (about 330,000+ monthly average) in 55 counties, using a network of approximately 24,000 active providers (BMS, October 2011). According to the WVCHIP 2011 Annual Report, approximately 176,000 of those members were children (based on enrollment as of June 30, 2011). For a summary of Medicaid enrollment for each of the eligibility categories for children based on qualifying income and age, please see Table 4 in section 2.3.2.2 below.

Approximately 165,000 Medicaid members (families with dependent children, low-income children, and pregnant woman) are enrolled in three managed care organizations (MCOs). Fifty percent are enrolled in Unicare Health Plan of WV, Inc.; 32 percent in Carelink Health Plans; and 18 percent in the Health Plan of the Upper Ohio Valley. The other Medicaid members are enrolled in the Primary Care Case Management (PCCM) program – the Physician Assured Access System (PAAS). Certain Medicaid eligible individuals are not eligible for the MCO or PAAS programs – Home and Community Based Services (HCBS) waiver clients, long-term care clients, foster care children, and Medicaid dually-eligible individuals (i.e., those eligible for both Medicaid and Medicare). Their services are paid according to a fee-for-service schedule. In addition, M-WIN is a Medicaid-funded work incentive program that allows working West Virginians with disabilities or chronic health conditions to pay a monthly premium to keep or obtain Medicaid health care coverage.

The ACA extends Medicaid eligibility to all adults below the age of 65 under 138 percent of the federal poverty level (FPL), based on new income calculation requirements (known as MAGI). West Virginia’s new Medicaid population will likely largely consist of uninsured non-disabled adults as currently Medicaid eligibility for adults is limited in West Virginia, covering working parents up to about 33 percent of FPL. The OIC will collaborate with BMS to develop state Medicaid enrollment projections as a result of health care reform. In addition, information gathered from an impending actuarial analysis will inform those projections.

2.3.2.2 West Virginia Children's Health Insurance Program (WVCHIP)

WVCHIP was created to help working families who do not have health insurance for their children. West Virginia CHIP provides coverage to children 18 or younger who live in West Virginia, meet the income guidelines, do not have health insurance and have not had coverage in the prior six months (for the Basic CHIP Plans) or the past twelve months for the CHIP Premium Plan, and are not eligible to receive West Virginia State Employee Health Insurance – PEIA or West Virginia Medicaid. CHIP offers three benefit programs depending on a child's age and household qualifying income: CHIP Gold, CHIP Blue, and CHIP Premium, which requires a monthly premium be paid. According to the WVCHIP 2011 Annual Report, enrollment in CHIP as of June 30, 2011, was 24,540 children. Please see Table 4 below for a summary of enrollment in WVCHIP and Medicaid for each of the eligibility categories for children.

Table 4: Health Coverage of West Virginia Children by WVCHIP and Medicaid – June 30, 2011

Qualifying Income (% FPL) ↓	**Infants** (<1 Year)	**Pre-school** (Ages 1-5)	**Primary School** (Ages 6-12)	**Secondary School** (Ages 13-18)
300%	**21**	**316**	**(WVCHIP Premium) 493**	**500**
200%	**92**	**316**	**10,149**	**9,410**
150%				
133%	**12,541**	**55,308**	**62,349**	**45,565**
100%				
Age Subtotals →	12,657	59,180	72,991	55,475

WVCHIP

Medicaid

Source: WVCHIP 2011 Annual Report, Enrollment

Total WVCHIP Enrollment: 24,540 **Total WV Medicaid Enrollment: 175,763**

As a result of the increase in the upper income limit for Medicaid in January 2014, many children that are now income-eligible for WVCHIP will move to Medicaid. The estimate is that WVCHIP will lose around 12,000 kids on this date. Other impacts of the ACA are still being determined (WVCHIP, 2010).

2.3.2.3 Other State Programs

AccessWV

AccessWV, the state's high risk insurance pool, guarantees that all West Virginians who qualify can purchase health insurance through the plan, regardless of their current and past health circumstances such as pre-existing, severe, or chronic medical conditions. Coverage through AccessWV is also available to persons with portability rights through HIPAA and to persons eligible for the Health Coverage Tax Credit. The program is authorized by the "Model Health Plan for Uninsurable Individuals Act" [W.Va. Code §33-48]. The Plan, which currently covers over 1,100 lives, was launched in July 2005 and operates through the OIC. On July 1, 2010, AccessWV began offering premium subsidies of 25 percent and 50 percent for those with household incomes to 200 percent of the FPL, expanding to 15-60 percent on July 1, 2011, for household incomes to 400 percent FPL.

Starting in 2014, the ACA requires insurance companies to provide coverage to every individual applying for health insurance, regardless of health status and pre-existing medical conditions (also known as "guarantee issue"). In addition, insurers will be prohibited from considering the health of an individual (or the average health of a small group) in determining what premium to charge. Consumers currently enrolled in AccessWV will be able to benefit from the access to affordable coverage as part of a broader risk pool through the Exchange. At some point a decision will need to be made about the future of AccessWV; the decision-making will be informed by a process of analysis of continued release of DHHS Rules regarding the Exchange and the state transitional reinsurance mechanism, post-2014 market projections, and determinations of the AccessWV Board of Directors. The option also remains for AccessWV to become a qualified health plan and participate in the Exchange. Funding was received in the Level One Establishment Grant for an analysis of transitioning current state health programs, including AccessWV, in 2014, which is also expected to inform the decision-making process.

Public Employees Insurance Agency (PEIA)

PEIA was established under the Public Employees Insurance Act of 1971 to provide hospital, surgical, group major medical, prescription drug, group life, and accidental death and dismemberment insurance coverage to eligible employees, and to establish and promulgate rules for the administration of these plans. PEIA insures the state's approximately 150,000 employees, 50,000 retirees, and 4,000 Medicaid/CHIP dual-eligible individuals. Benefits are made available to all active employees of the state of West Virginia and various related state agencies and local governments.

To aid in decision-making about the future of PEIA, the impact of PEIA-eligible consumers (current and early retiree) moving into the Exchange will be assessed as part of the impending actuarial analysis.

West Virginia Small Business Plan

The West Virginia Small Business Plan was created as a result of Senate Bill 143, passed in March 2004, with the goal of making more affordable health insurance available to working adults through employer-sponsored plans. The Small Business Plan is a partnership between insurance companies, PEIA and health care providers. The Plan advertises expected premium cost reductions ranging between 17-22 percent compared with similar commercially available policies; these reductions are primarily achieved by leveraging lower PEIA provider reimbursement rates. To keep rates low, carriers also receive reduced administrative fees for plan contracts. The program received a multi-year $1.3 million grant through 2007 from the Robert Wood Johnson Foundation to support creation and promotion of the Small Business Plan, but the program is unique from similar ones offered by other states in that no West

Virginia state budget funds are dedicated to underwriting the costs of the Small Business Plan (Source: www.wvsbp.org).

To participate, small businesses must: have 2-50 employees; have been without a company-sponsored health plan for the prior 12 consecutive calendar months; pay at least 50 percent of the individual premium costs; have 75 percent participation from eligible employees; and been in existence for at least the past 12 consecutive months. Participation by small business groups has been lower than expected; as of March 2010, 1,732 West Virginians from 360 businesses were covered through the plan. Participation averaged 34 months, and the majority of groups employed 2-9 people (WV Health Care Authority, February 2011).

Although all insurance carriers licensed to sell major medical insurance in West Virginia can issue policies for the Small Business Plan, Highmark BlueCross BlueShield was the first and remains the only participating carrier.
Employers with 2-50 employees enrolled in the Small Business Plan will be able to benefit from increased purchasing power, lower cost, and expanded coverage options through the Exchange beginning in 2014. A decision regarding the future of the Small Business Plan needs to be made. Funding was received in the Level One Establishment Grant for an analysis of transitioning current state health programs in 2014, including the Small Business Plan, and is expected to inform the decision-making process.

2.3.3 Alternative Coverage Models

One of the many ways in which the provisions of the ACA are changing the healthcare marketplace is by allowing, and sometimes promoting, alternative health insurance models that can be considered qualified health plans under certain conditions. This section discusses the implications of three of these models.

2.3.3.1 Direct Primary Care

The Direct Primary Care Coalition describes practices that use this model as follows: “Direct primary care practices serve as a patient's ‘primary care medical home’ (D-PCMH) where they go for all routine primary, preventive and chronic care management types of care. Patients pay one…monthly fee…directly to their direct primary care facility for all of their everyday health needs.” There is no involvement with insurance reimbursement, “no procedure or billing approval, deductibles or co-payments” (Direct Primary Care Coalition, 2011). Such practices often also have extended access for patients by virtue of extended hours and/or phone and email accessibility. Most patients have wraparound insurance to address specialized or more serious health needs, often with a high deductible. Some of these physicians see patients with traditional insurance as well. Plan costs vary, but are typically in the vicinity of $50 to $150 per month.

While currently there are relatively few physicians in these practices (estimated at fewer than 1,000 in the U.S. at the end of 2009) (Trapp, 2011) their numbers have been growing. Starting in 2014, the ACA will allow these practices, in concert with a wraparound insurance plan,[8] to be considered a qualified health plan if they meet all other applicable requirements. The proposed regulations issued with respect to these practices are minimal, and the Centers for Medicare and Medicaid Services (CMS) have specifically requested additional comment in this area. The

[8]The wraparound plan covers rare and unpredictable services outside of primary, preventive and chronic care, such as specialist care, hospital stays or emergency room visits.

regulations do indicate that a single payment should be made for both primary and wraparound coverage for the sake of simplicity, and that there must be coordination between these two entities. One important motivation for CMS' decision that coverage through direct primary care medical homes could not be purchased without a wraparound insurance plan is that these groups "are providers, not insurance companies, which would require the Exchange to develop an accreditation and certification process that is inherently different from certifying health plans and that would significantly depart from the role of an Exchange" (DHHS, 2011).

While CMS indicated that it views these entities as providers, others have not always made the same determination. Some states have at times seen these entities as insurers and tried to make them subject to insurance regulations. New state legislation to allow these entities has evolved as a result, most notably in Washington state. In 2006, West Virginia, allowed physicians to provide direct primary care on a retainer basis for a three-year pilot period that began in 2007; the program was subsequently extended for one year and then allowed to expire, however the three existing retainer practices were allowed to continue (Trapp, 2011).

There remain many other questions related to the use of this model. Can coordinated care be assured with the involvement of two entities – the primary care practice and wraparound plan? What will the combined insurance costs be? Reviewers have noted that there is not sufficient evidence to know if this model can save money or provide higher quality care than traditional models. West Virginia, along with other states, will need to monitor this evolving corner of the market.

2.3.3.2 Consumer Operated and Oriented Plans (Co-ops)

Co-ops are non-profit, non-governmental entities that can provide insurance and become qualified health plans. This provision was added to the ACA as a compromise when the public option was eliminated. There are a number of restrictions in the ACA and proposed rules on who can form cooperatives, how they are governed and what products they can sell. The federal government is providing grants and loans to assist these groups with start-up. Reflecting the difficulty of implementing these entities in a financially sustainable way, the U.S. Department of Health and Human Services (DHHS) is expecting a default rate in the neighborhood of 40 percent.

New co-ops will typically be at a disadvantage when negotiating payment rates with providers, resulting in a competitive disadvantage when looking for enrollees. Co-ops may establish councils to do joint purchasing for administrative services, but they may not set provider rates. Similarly, DHHS may not participate in negotiations between co-ops or councils and providers or set reimbursement levels. Typically, successful health care cooperatives have been closely tied to networks of providers. In West Virginia, the community health centers are looking to form a co-op that will do just that, called the "West Virginia Family Health Plan". They are hoping to join with a broad spectrum of providers in order to provide a continuum of care. Community health centers occupy a special niche in the world of health care delivery. Since they exist in every state and are linked through national organizations they have the potential to become multistate networks. Additionally, every qualified health plan sold through the state exchanges must include essential community providers in its network which could improve this group's chances of success.

West Virginia's decision about whether to be an active or passive purchaser (i.e., what requirements it establishes for the purposes of certifying qualified health plans) will affect co-

ops. Higher certification standards can shift the competitive edge toward plans with higher value, which may be particularly important in concentrated markets in order to support competition. Advocates hope that the presence of co-ops and other consumer-oriented plans will push commercial plans to be more competitive. The importance of enhanced competition within the Exchange will depend on how successful it is in capturing a substantial part of the health insurance market. While looking to gain market share, it will be equally important to avoid adverse selection, which would have a disproportionate negative impact on these typically financially frail entities. It will also be very important for any co-op to be operational when the Exchange begins operations, in order to be one of the options available for initial enrollment.

2.3.3.3 Accountable Care Organizations (ACOs)

Accountable Care Organizations are organizations of providers, typically anchored by one or more hospitals, which include primary care physicians, specialists and possibly other providers. They are held accountable for the cost and quality of the care provided to their panel of patients. They share risk with payors, reaping a bonus if they save money and in some models facing financial penalties if their services are too costly. CMS recently finalized rules governing ACOs for the purposes of Medicare reimbursement.

The issues brought to the fore by ACOs are not closely tied to the development of Exchanges. The primary issues are those related to competition and concentrated markets. While ACOs are an important step toward aligning the financial incentives of payors and providers, this model can also easily concentrate market influence. This is particularly an issue if, for example, there is one local hospital. Some observers have expressed concern that the federal government has just issued antitrust guidance that reduces enforcement related to potential antitrust violations. Will a hospital want to contract with a managed care entity if it is part of an ACO?

However, there may be ways to create market synergies. In an article written for the California Association of Health Plans (Polakoff and Boland, 2011), the authors note:

> *It makes strategic and business sense for health plans and providers to collaborate on how to take substantial cost out of the delivery system…Health plans have core assets such as marketing, claims data, claims processing, reimbursement systems and capital. It would be cost-prohibitive for all but the largest providers in the state to develop these capabilities in order to compete directly with insurers. Likewise, medical groups and hospitals are positioned to foster financial interdependence among providers and coordinate the continuum of patient illnesses and care settings.*

ACOs are just beginning to be established; at least one group in West Virginia is discussing the possibility of forming such an entity. ACOs market influence will depend on how many are developed, the incentive systems employed and how many payors adopt the model alongside Medicare. While broader market forces are at play, as previously discussed with respect to co-ops, Exchanges can affect ACO usage by the way they define qualified health plans. This is one more evolving area where monitoring will be critical.

2.3.4 Producers

Nearly 5,000 resident and 25,000 non-resident agents and brokers (or “producers”) play a valuable role assisting individuals and small businesses in West Virginia to purchase health insurance, helping them navigate the confusing landscape that makes up the health insurance market today. They assist with obtaining prices for coverage; comparing and selecting plans that best fit the needs of individuals, businesses, and their employees; and completing the

application and enrollment process. For small businesses in particular, they often provide ongoing support after the purchase of insurance such as assisting employees with resolution of coverage, billing, or customer service issues. Brokers often have trusted relationships with businesses, providing a range of services beyond selling health insurance, including assistance with dental and vision insurance, disability coverage, life insurance, and other ancillary lines of coverage. Although the Exchange will streamline and simplify the process of purchasing health insurance for consumers through the use of a web portal, benefit standardization, increased transparency, and support via a call center, producers will continue to play an important role helping West Virginia individuals and employees of small businesses obtain health insurance coverage. Their involvement directing and assisting the thousands of consumers expected to be eligible for coverage through the Exchange will be essential to its ultimate success.

Massachusetts' and California's experiences underscore the importance of the role these brokers play assisting small business. In Massachusetts, observers thought small group purchasing would be done directly through the Connector. However, small employers continued to purchase coverage almost exclusively through brokers. Designers believed small employers would prefer to offer a range of choices from different health plans, while employers valued the administrative simplicity brokers provide, particularly since it was no cheaper to purchase insurance from the Connector. Massachusetts responded by restructuring its small business program. The role of brokers was not as significant in the individual market in that state.

California set broker commissions below the prevailing small group rates and allowed employers to eliminate commissions by purchasing coverage directly from the Health Insurance Plan of California (HIPC). Brokers in turn did not promote the HIPC, impacting enrollment. If incentives for brokers inside and outside the exchange differ, it can affect enrollment in two ways – by reducing the number of enrollees choosing Exchange products as just described, and by leading to adverse selection if producers direct higher-risk enrollees to the Exchange. Such activities allegedly occurred in California. The HIPC subsequently adjusted its broker fees to be comparable to those in the commercial market, and eliminated the financial incentive for small employers to purchase directly from the HIPC. The ACA provides some protections against such potential adverse selection risk, but they are untested and almost certainly imperfect (AcademyHealth, 2010).

Discussions on how to compensate producers at reasonable commission rates while maintaining a low administrative cost structure will occur as Exchange planning progresses. Downward pressure may be exerted on commissions by the new 80 percent limit on medical loss ratio (MLR) for individual and small groups. As of now, broker fees are included in that calculation, but brokers are lobbying to change that provision. West Virginia has some limits on MLR, which reportedly has not had a major impact on the market, although some brokers have stopped selling plans that do not give commissions. Additionally, the mechanism for paying commissions for products purchased through the Exchange will need to be developed. Utah, for example, uses a contractor to manage this service.

To provide an idea of current commissions, the table below provides producer commission averages in West Virginia and the United States from 2010 based on insurer filings to the National Association of Insurance Commissioners.

Table 5: Producer Commission Averages

	Individual Market		Small Group Market	
	PMPM	Fee as % of Premium	PMPM	Fee as % of Premium
West Virginia	$16.69	6.2%	$18.51	5.0%
United States	$12.10	5.7%	$15.37	4.6%

Data Source: statehealthfacts.org

West Virginia sought early involvement of producers in discussions about state Exchange policies and design. Toward their mutual benefit, the state and producers will continue their relationship and communications through regular monthly meetings, and once established, within the structure of Exchange Board. In addition, the contractor hired to complete the actuarial analysis will provide additional information on the existing producer market and recommendations for how the Exchange will compensate them for services provided assisting members enroll in health insurance programs through the Exchange. See Table 6 below for specific information to be obtained.

2.4 Actuarial Analyses Required to Complete Market and Industry Analysis

To gain the clear, comprehensive understanding of the current health insurance market and industry within West Virginia needed for Exchange planning, a contractor with actuarial and economic expertise will be secured to perform a thorough analysis of the existing state of and projected impact on the following as a result of the ACA: the uninsured, underinsured, and insured populations; the small employer group market; the affordability of coverage statewide; and an overview of the state's private health insurance marketplace including carriers and producers. The RFP for these services is developed and is under state review as of November 2011; once approved, it will be issued using standard state purchasing rules unless the Board is in place and may exercise their exemption. Table 6 below provides a summary of the information that will be acquired through the contractor to assist with Exchange planning and decision-making.

Table 6: Summary of Market and Industry Information to be Obtained Through Actuarial Analysis

Market/Industry Topic	Description of Information to be Obtained
Uninsured and Underinsured	Descriptive and quantitative analysis of the uninsured, underinsured, and insured including household income and size, geographic location, age, race and ethnicity, employment status (including employer size and type of coverage offered, if any), and eligibility for public programs.
	Future projections for the uninsured in West Virginia.

Market/Industry Topic	Description of Information to be Obtained
	Number of insured by different insurance market segments (e.g., individual, Medicaid, self-insured, military).
	Trends in coverage for the past 10 years and projections for the next 10 years, stratified by insurance market, geographic location, and household income.
	Future projections for the number of individuals to be insured in public health care programs, such as Medicaid, as a result of ACA-mandated eligibility expansions.
Small Business Health Options Programs	Descriptive and quantitative analysis of the small group population stratified by household income and size, geographic location, age, race and ethnicity, employment status (including employer size and type of coverage offered, if any), and eligibility for public programs.
	Estimates for each year 2014 – 2016 assuming the state implements the Exchange for the small group (both combined with the individual risk pool or separate) by groups with 1 to 25 employees, 26 to 50 employees, 51 to 100 employees, and 101+ employees.
	Analysis of the number of WV residents who work across state lines and the number of non-residents who work within the state, including data and a description of the type of health insurance plans offered with participation rates; a descriptive analysis of the impact of pooling risk with surrounding states will also be developed
	Analysis of the number of small business groups that are eligible for tax credits and at what level, including an assessment of current and projected take-up of employer tax credits, an assessment of employee take-up of health insurance in each group size, assessment of employee per month health insurance cost to the employer and the employee of each group size.
	Projection of the number of employers that may opt to not participate in the SHOP and the impact it will have on the individual market.
Coverage Affordability	Estimate of insured individuals whose total out-of-pocket spending costs consume more than ten percent of the policyholder's income.
	Estimate of the average premium within the individual, small and large group markets as a percentage of income stratified by household income level, geographic location, age, and race.
	Determination of how the market will respond to price changes within and out of the Exchange taking into consideration the share of the health premium as part of household income and the amount of public subsidy.
	Analysis of transition of current and future consumers of the Exchange beginning in 2011 to after 2014.
	Side-by-side analysis of CHIP subsidy verses Exchange premium tax subsidies.
	Descriptive analysis of individuals in the following income thresholds based

Market/Industry Topic	Description of Information to be Obtained
	on the Federal Poverty Level (FPL): Below 133%, 140% to 200%, 201% to 300%, 301% to 400%, 401% or more.
Health Insurance Marketplace	Descriptive analysis and survey of each carrier and producer in West Virginia, including: number of products in each market, and the range of premiums charged for these products; number of policyholders insured in each product; common benefit design and associated cost-sharing among commercial health insurance products; relationships between benefit design and premiums; regional variation in provider networks and network adequacy among commercial health insurance products; agent commission structure; and an analysis of price points for producer services.
	Estimate of the number of insurance brokers and agents licensed in West Virginia who sell, market or distribute health insurance to groups and individuals in the state, including a summary of the following: geographic distribution of target markets, commission structure and compensation ranges, and definition of the per producer/per carrier sales relationship broken down into blocks or lines of business using a 20 year time span (10 years back and 10 years forward).
	Estimate of the range of commission that has historically been paid to producers by insurers in the individual and small group health insurance markets.
	Analysis and pro and con scenarios of flat fee compensation to producers versus a percent of premium, including some judgment as to the additional (or lessened) work expected for producers under the reforms given the probable increase in business from the individual mandate, government subsidies and the new information, comparability, online eligibility and functionality associated with the HBE.

3.0 Governance

3.1 Exchange Purpose and Operational Environment

As provided for in West Virginia Senate Bill 408, the Health Benefit Exchange is established in the Offices of the Insurance Commissioner as a governmental entity of the state. Its purpose is: "to facilitate the purchase and sale of qualified health plans in the individual market in the state and a Small Business Health Options Program within the Exchange to assist qualified small employers in this state in facilitating the enrollment of their employees in qualified health plans." Per the Bill, the Exchange shall pursue available federal funding for the operation of the Exchange and shall promulgate rules necessary to obtain federal recognition of the Exchange as a certified Exchange under the ACA. To aid in doing so, the Exchange is exempted from the rules of State Purchasing[9] and State Personnel and is permitted to enter into information-sharing agreements with state or federal agencies as well as other state Exchanges.

3.2 Exchange Board

3.2.1 Structure

Senate Bill 408 established an independent Board with legislative and emergency rule-making authority to provide supervision and control over West Virginia's Health Benefit Exchange. The approach adopted by the West Virginia Legislature creates a Board that balances stakeholder perspectives, ensuring all parties involved are fully engaged in making the Exchange a success. Accordingly, the Exchange Board created by the bill is comprised of the following ten seats:

- *Four voting ex officio heads of West Virginia state agencies,* including the Insurance Commissioner, the Chair of the Health Care Authority (HCA), the Commissioner of the Bureau for Medical Services (BMS), and the Director of Children's Health Insurance Program (CHIP);
- *Four persons appointed by the Governor with the advice and consent of the Senate who are to represent individual consumers, small employers, organized labor, and insurance producers;*
- *One person to represent the interests of payors*, selected by a majority vote of an advisory group comprised of representatives of the ten carriers with the highest insurance premium volume in West Virginia in the preceding calendar year; beginning in 2014, the advisory group will be comprised only of representatives of carriers selling qualified health plans in the Exchange regardless of premium volume, provided that the member is not an employee or affiliate of a carrier on the advisory group; and,
- *One person to represent the interests of health care providers*, selected by a majority vote of an advisory group comprised of a representative from the West Virginia Association of Free Clinics, West Virginia Hospital Association, West Virginia State Medical Association, West Virginia Primary Care Association, West Virginia Nurses Association, West Virginia Society of Osteopathic Medicine, West Virginia Academy of Family Physicians, West Virginia Pharmacists Association, West Virginia Dental Association, West Virginia Behavioral Health Care Providers, West Virginia Chiropractic Society, West Virginia Optometric Association, West Virginia Podiatric Medical Association, West Virginia Physical Therapists Association, and a full-time health officer

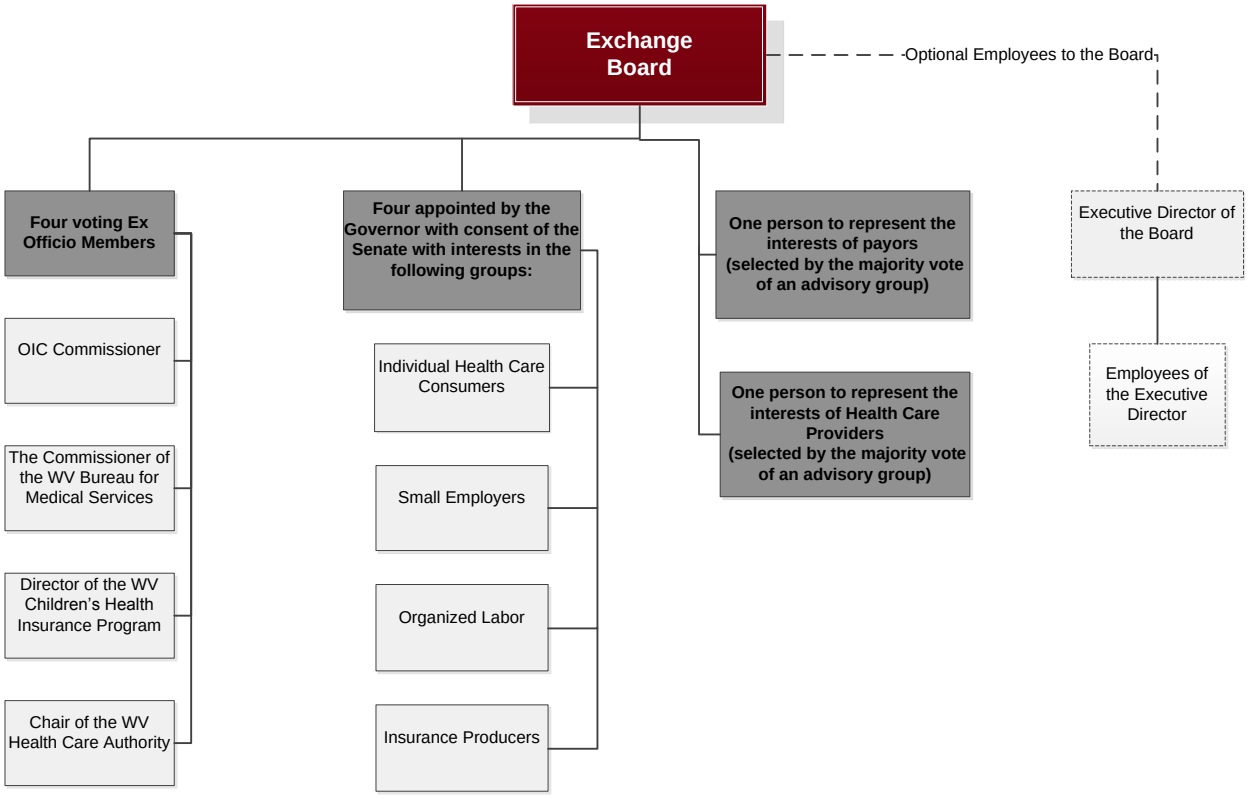
[9] Contracts must still be awarded on a competitive basis.

of a county or regional health department selected by all full-time health officers of all county or regional health departments.

Governor-appointed members will serve staggered terms, and after the first series of terms will serve four-year terms. Each member will serve a term of four years and is eligible to be reappointed, except that the term of each of the four persons initially appointed to represent the following groups will be as follows: individual consumer, one year; small employers, two years; labor, three years; and producers, four years. Any appointed or selected member whose term has expired may continue to serve until either he or she has been reappointed or his or her successor has been duly appointed or selected.

With the advice and consent of the Senate, the Governor appoints a Board Chairperson from the membership described above (see Figure 2 below for a visual depiction of the Exchange Board).

Figure 2: West Virginia HBE Governance Structure



3.2.2 Responsibilities

According to Senate Bill 408, the Exchange Board's responsibilities include the following:

- The Board may employ an Executive Director who has overall management responsibility for the Exchange and such employees as may be necessary. The

Executive Director and employees of the Exchange will receive a salary, as provided by the Board.

- The Board may establish ad hoc or standing advisory committees of consumers and other stakeholder groups or interested parties to study particular policy issues and to advise the Board.
- The Board must make an annual report to the Governor and also file it with the Joint Committee on Government and Finance. The report shall summarize the activities of the Exchange in the preceding calendar year.
- The Board may assess fees on health carriers selling qualified dental plans or health benefit plans in West Virginia, including health benefit plans sold outside the Exchange, and shall establish the amount of such fees and the manner of the remittance and collection of such fees in legislative rules.
- If any portion of the federal Affordable Care Act or of any regulation or other guidance issued thereunder is invalidated or repealed, the Board will issue recommendations to the Legislature for amendments to Senate Bill 408 as necessary.
- A special revenue account in the State Treasury, called the "West Virginia Health Benefits Exchange Fund", will be administered by the Board and used to pay all costs incurred in implementing the provisions of the Bill.

3.2.3 Rules and Procedures

According to Senate Bill 408, the rules governing the Exchange Board include the following:

- Board members may be removed by the Governor for cause.
- Members of the Board are not entitled to compensation for services performed as members but are entitled to reasonable reimbursement for costs incurred while performing Board duties.
- Seven members of the Board constitute a quorum, and the affirmative vote of six members is necessary for any action taken by vote of the Board. No vacancy in the membership of the Board impairs the rights of a quorum by such vote to exercise all the rights and perform all the duties of the Board.
- Neither the Board nor its employees are liable for any obligations of the Exchange. No member of the Board or employee of the Exchange is liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under this article unless the act or omission constitutes willful or wanton misconduct. The Board may provide in its bylaws or rules for indemnification of, and legal representation for, its members and employees.
- Board members must undergo ethics training within six months of appointment and every two years thereafter.

3.3 Bylaws, Procedural Rules, and Procedures

3.3.1 Exchange Board Bylaws

Bylaws governing internal management of the Board have been drafted and will be proposed to the Board for approval when it is seated. When final, the bylaws will be available at www.bewv.com. Key sections of the bylaws address the following:

- Powers and duties of the Board;
- Prohibitions on what the Board may do;
- Board membership, terms, vacancies, and compensation;

- Board officers including chairperson, other officers, election rules, secretary of the Board, chain of command, and absentee officers;
- Board meetings including frequency, special and emergency meetings, time and location, agendas, notices, minutes, quorum rules, telephonic attendance, voting, executive sessions, presiding officer procedure and decorum, and procedural rule;
- Hiring and providing authority to an Executive Director, limits on his/her authority, and emergency decision-making and meetings;
- Establishment of subcommittees;
- Board immunity and indemnification rules; and,
- Amendments to the bylaws.

3.3.2 Exchange Board Meeting Procedural Rules

Procedural rules governing Exchange Board meetings have been drafted and will be proposed to the Board for approval when it is seated. When final, the procedural rules will be available at www.bewv.com. Key sections of the rules address the following:

- Responsibility for application and enforcement of the procedural rules;
- Rules related to Board officers;
- Scheduling and providing notice of meetings and meeting agendas;
- Opening meetings, discussion, motions and voting;
- A citizen's right to address the Board;
- Openness of meetings to the public and exceptions to that openness, including executive sessions;
- Establishment of subcommittees;
- Meeting minutes; and,
- The public nature of Board records.

3.3.3 Advisory Group Election Procedures

Pursuant to W. Va. Code §33-16G-5(b)(4), an advisory group comprised of representatives from provider organizations and another advisory group comprised of representatives from payors are separately charged with selecting – by majority vote – a Board member to represent the respective interests of the two groups. Pursuant to §33-16G-5(b)(5), the chairperson of the Board, as selected by the Governor, will determine the manner and time of selection of the members of the Board by the groups. A draft of recommended procedures for assembly of the advisory groups and for them to perform their duty of selecting Board members to represent the interests of health care providers and payors has been developed for review and approval by the Chair once he/she is selected. When final, the procedural rules will be available at www.bewv.com. Key sections of the procedures address the following:

- Contact with the provider organizations and payors and creation of the advisory groups;
- Nominations, scheduling, and holding of the advisory group meetings;
- Advisory group meeting procedures and selection of the Board members; and,
- Additional miscellaneous provisions.

3.4 Ethics Training

Per Senate Bill 408, Board members must undergo ethics training within six months of appointment and every two years thereafter. The West Virginia Ethics Commission has indicated their willingness and ability to assist the Exchange in executing the requirements set forth in the legislation and has agreed to review various Exchange policies to ensure the most

prudent course is followed with regard to transparency and openness. In early 2012, the Exchange planning team, with assistance from OIC Legal Counsel, will partner with the Ethics Commission to develop ethics policies and training for the Board. Grant funding was secured from the federal government in the Level One Establishment Grant to support these efforts, and it is anticipated that additional funds will be requested in the Level Two Establishment Grant for additional training in 2014.

4.0 Mission, Vision, and Goals

An organization's mission is a statement of purpose, describing what it does and why it exists. Its vision provides a future-oriented concept of the organization and serves as a source of inspiration. Guiding principles convey the underlying assumptions and values that define and direct the organization and its decisions, and strategic goals also guide business processes and decisions, including the organization's architectural and operational design and what long-term strategic framework will be built. The goals provide a guide to action, as well as a means of measuring performance.

Based on feedback gathered from West Virginians across the state through stakeholder meetings, responses to the formal state request for comments, and guidance provided by state leaders in Senate Bill 408 and the federal government in the ACA, a proposed mission, vision, and set of guiding principles have been developed for the Exchange. Approval will be sought from the Board when it is in place, and strategic goals will be developed.

Table 7: Proposed Exchange Mission, Vision, Guiding Principles, and Goals

West Virginia Health Benefit Exchange	
Proposed Mission	The West Virginia Health Benefit Exchange will maximize the number of insured West Virginians, provide consumers with reliable health insurance information, and promote a competitive marketplace that allows individuals, families, and businesses to choose the health plan that provides them the best value.
Proposed Vision	The West Virginia Health Benefit Exchange will be a trusted and easy-to-use guide for the health insurance marketplace that allows West Virginians to understand, compare, and enroll in available health insurance plans based on benefits, quality, and cost.
Proposed Guiding Principles	1. Protect viability of health insurance market. 2. Increase access to health insurance coverage options. 3. Increase portability and choice for health insurance. 4. Increase transparency in the purchase of health insurance. 5. Facilitate payment for coverage from assorted sources. 6. Standardize and simplify health insurance purchase. 7. Standardize method by which health insurance eligibility is determined. 8. Standardize method by which health insurance enrollment takes place. 9. Increase continuity of care through consumer payer source transitions. 10. Encourage value-based competition and plan innovation. 11. Achieve sustainable financial model for health insurance Exchange operations.
Strategic Goals	To be developed when Board is in place.

5.0 Core Exchange Services

At its core, the Exchange: serves as a market organizer of health insurance for consumers in West Virginia; provides a transparent source of simplified health insurance information; streamlines eligibility determination and enrollment for public health insurance, advance payment of premium tax credits, and cost-sharing reductions; simplifies health insurance enrollment and administration for consumers, employers, and carriers; and expands the size of risk pool for consumers. The Exchange is not an insurance company; rather, it serves as a distribution channel providing access to a consumer-friendly shopping experience for West Virginians seeking coverage from private and public entities that provide health insurance. Although it is not intended to handle commercial health plan and public program customer service issues, benefit questions, and claims issues, as part of its consumer assistance functions DHHS encourages the Exchange to use call centers as a conduit to other state consumer programs, such as health insurance ombudsman, and to coordinate with qualified health plan issuers' customer call centers (DHHS, 2011).

5.1 Exchange Benefits

The major benefits of Exchange services accrued to the consumers and employers of West Virginia include: 1) simplified access to and enrollment in affordable, comprehensive, quality health insurance, and 2) access to advanced payment of the tax credit for individuals and the small business health care tax credit for small employers. The state Exchange is uniquely positioned in the marketplace to fulfill these services and deliver these benefits to West Virginia consumers for reasons including the ability to:

- Interface with federal and state agency data sources to create a single, streamlined process for determining individual eligibility for the premium tax credit, cost-sharing subsidies, and public health programs, as well as the small employer health care tax credit;
- Directly enroll consumers into public programs and qualified heath plans;
- Combine individuals and small businesses[10] into larger risk pools, spreading risk and reducing cost; and,
- Ensure minimum standards for plan benefit design and actuarial value.

5.1.1 Cost-Sharing Subsidies and Premium Tax Credits

To make health insurance coverage more affordable, beginning in 2014 many West Virginians will receive help to purchase private health coverage through the Exchange in the form of cost-sharing subsidies and premium tax credits. Cost-sharing assists families with incomes at or below 250 percent of poverty by making them eligible to enroll in health plans with higher actuarial values, and it reduces out-of-pocket limits for people with incomes at or below 400% of poverty.

The premium tax credit is available to individuals and families with household incomes between 100 percent-400 percent of the federal poverty level. Covered individuals must purchase

[10] A determination as to whether or not the individual market risk pool will be combined with the small employer risk pool in West Virginia has not been made yet.

coverage through the Exchange, must be legally present in the U.S., must not be incarcerated, and must not be eligible for other qualifying coverage such as Medicare, Medicaid, or employer-sponsored coverage. However, tax credits are available to qualified individuals offered (but not enrolled in) employer-sponsored insurance if (a) it is "unaffordable" (meaning that the self-only premium exceeds 9.5 percent of household income); or (b) it does not provide a minimum value (meaning it fails to cover 60% of total allowed costs).

Consumers will have access to an electronic premium calculator that allows them to estimate their actual cost of coverage after the premium tax credit is applied when shopping for health plans on the Exchange. Advanced payment of the premium tax credits will be made by the U.S. Department of the Treasury directly to the insurance company on behalf of a qualifying family, which will then be reconciled against the amount of the family's actual premium tax credit, as calculated on the family's federal income tax return. Any repayment due from the taxpayer is subject to a cap for taxpayers with incomes under 400 percent of federal poverty level (U.S. Treasury, August 2011). The following are examples from the U.S. Treasury of how the premium tax credit works:

Example 1: Family of Four with Income of $50,000, Purchases Benchmark Plan

The premium tax credit is generally set based on the benchmark plan. The family's expected contribution is a percentage of the family's household income.

- Income as a Percentage of FPL 224%
- Expected Family Contribution: $3,570
- Premium for Benchmark Plan: $9,000
- Premium Tax Credit: $5,430 ($9,000 - $3,570)
- Premium for Plan Family Chooses: $9,000
- Actual Family Contribution: $3,570

Example 2: Family of Four with Income of $50,000, Purchases Less Expensive Plan

If a family chooses a plan that is less expensive than the benchmark plan, the family will generally pay less, thereby creating an incentive to choose a less costly plan and reducing overall health care costs.

- Income as a Percentage of FPL 224%
- Expected Family Contribution: $3,570
- Premium for Benchmark Plan: $9,000
- Premium Tax Credit: $5,430 ($9,000 - $3,570)
- Premium for Plan Family Chooses: $7,500
- Actual Family Contribution: $2,070 ($7,500 - $5,430)

Example 3: Family of Four with Income of $50,000, Parents are between the ages of 55 and 64

Because premiums are generally higher for older individuals, the premium tax credit also is higher for these individuals.

- Income as a Percentage of FPL 224%
- Expected Family Contribution: $3,570
- Premium for Benchmark Plan: $14,000
- Premium Tax Credit: $10,430 ($14,000 - $3,570)
- Premium for Plan Family Chooses: $14,000
- Actual Family Contribution: $3,570

5.1.2 Small Business Health Care Tax Credit

The ACA also provides for a Small Business Health Care Tax Credit to help small businesses afford the cost of covering their workers. Although the tax credit became available in January 2010 and covers up to 35 percent of the premiums small businesses pay to cover its workers, the rate will increase to 50 percent in 2014. At that time, employers will need to purchase coverage through the SHOP Exchange to access the tax credit. While the Exchange will perform a preliminary calculation to determine whether employers may be eligible for the tax credit, the credit will be administered by the IRS.

To be eligible for the tax credit, a small business must: 1) cover at least 50 percent of the cost of single (not family) health care coverage for each employees, 2) have fewer than 25 full-time equivalent employees (FTEs), and 3) must have average employee wages of less than $50,000 a year. The tax credit phases out gradually for firms with average wages between $25,000 and $50,000 and for firms with the equivalent of between 10 and 25 full-time workers. Employers can be for-profit or tax-exempt. The following are examples of how the small business health care tax credit works (Internal Revenue Service, December 2011):

Example 1: Auto Repair Shop with 10 Employees Gets $24,500 Credit for 2010
***Main Street Mechanic*:**
Employees: 10
Wages: $250,000 total, or $25,000 per worker
Employee Health Care Costs: $70,000

2010 Tax Credit: $24,500 (35% credit)
2014 Tax Credit: $35,000 (50% credit)

Example 2: Restaurant with 40 Part-Time Employees Gets $28,000 Credit for 2010
Downtown Diner:
Employees: 40 half-time employees (the equivalent of 20 full-time workers)
Wages: $500,000 total, or $25,000 per full-time equivalent worker
Employee Health Care Costs: $240,000

2010 Tax Credit: $28,000 (35% credit with phase-out)
2014 Tax Credit: $40,000 (50% credit with phase-out)

Example 3: Foster Care Non-Profit with 9 Employees Gets $18,000 Credit for 2010
First Street Family Services.org:
Employees: 9
Wages: $198,000 total, or $22,000 per worker
Employee Health Care Costs: $72,000

2010 Tax Credit: $18,000 (25% credit)
2014 Tax Credit: $25,200 (35% credit)

5.2 Exchange Minimum Functions

To provide its core services, the Exchange is required by federal law to perform several minimum functions, including:

- Maintaining an Internet Web site;
- Determining eligibility and enrolling consumers in public health insurance affordability programs and qualified health plans, including providing a single point of entry for consumers by using an application form that can be submitted online, by mail, through a call center, or in person;
- Qualifying certain employers for small business tax credits for premium contributions;
- Providing a calculator for consumers to determine the amount of their premium after subsidies have been calculated;
- Aggregating small employer premiums to simplify the administration of health benefits;
- Providing consumers with standardized, simplified plan descriptions and comparative data;
- Identifying individuals who are exempt from the federal insurance mandate;
- Establishing a process for appeals of eligibility determinations;
- Interfacing with related systems to obtain and provide information, including federal systems;
- Fulfilling oversight and financial integrity requirements;
- Certifying and de-certifying qualified health plans;
- Evaluate quality improvement strategies and assign plan quality ratings;
- Requiring participating plans to justify rate increases; and,
- Contracting with Navigators to provide public education and facilitate enrollment.

Future plans to be considered for expansion of Exchange services include:

- Allowing large employers (greater than 100 employees) to use the SHOP in 2017 (DHHS, 2011); and,
- Facilitating horizontal eligibility determination for other public programs such as Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP).

6.0 Business/Project Risks

Risks are an inherent aspect of the development of any new business, particularly one with the social, financial, and political magnitude of the Exchange. However, a well-executed risk management plan can bolster the stability and ultimate success of the business by recognizing and accounting for those risks in the planning process. A number of risks to the planning, establishment, and operations phases of the Exchange are being addressed as part of the ongoing project management process; however a few key risks and elements of the plan to address them are highlighted below.

6.1 Key Risks to Exchange Planning, Establishment, and Operations

Major risks to successful Exchange planning, establishment, and operations in 2014 and beyond include:

- **The ability to meet aggressive federally-mandated timelines.** By January 2013, the state must demonstrate that the Exchange will be prepared to begin initial enrollment on October 1, 2013, and be fully operable by January 1, 2014. Mitigation strategies to address the risk of failing to meet those timelines include: leveraging existing state resources and hiring contractors to perform planning activities until Exchange staff can be hired; using the exemption from state personnel and procurement rules once the Board is seated to expedite hiring and procurement processes; securing grant funding at the earliest stage possible based on meeting federal requirements; and proactively researching, identifying, and sharing decisions that may need legislative action with state leadership.

- **Possibility of low engagement and participation of key stakeholder groups such as individuals, the business community, producers, and health insurance carriers.** The Exchange must attract sufficient enrollment volume to support the fixed costs of operations and become a financially self-sustaining entity, as well as to create the large, stable risk pool that will allow coverage to become more affordable for individuals and small businesses. A viable business opportunity must be present for carriers to choose to sell qualified health plans in the Exchange and for producers to encourage enrollment of individuals and employees into those plans. Mitigation strategies for these risks include creation of an effective communications and outreach strategy (see Section 7.0), development of policies to reduce adverse selection for carriers and to provide fair and reasonable compensation to producers, and creation of a streamlined, simplified process within the Exchange that allows for easy enrollment, billing, and payment processing.

- **The possibility that the U.S. Supreme Court will find provisions of the ACA unconstitutional.** A critical overarching risk to Exchange planning, establishment, and operations is, the full implications of such as decision are unclear at this time, however Senate Bill 408 considers this risk by declaring that in the event any portion of the ACA or any regulation or guidance issued under it is invalidated and rendered of no effect, the Exchange Board must immediately issue a bulletin setting forth its legal opinion as to the effect of the action on the corresponding provisions of the act, regulations, or guidance, and must issue recommendations to the Legislature for amendments to the bill. This risk

has been accepted by Exchange planners and is being actively monitored; regular updates on its status are provided to state leadership.

The Exchange planning team continually monitors known risks and identifies new ones, reviewing and updating them regularly and determining how best to manage them. Section 6.2 below describes the risk management approach employed by the Exchange team.

6.2 Approach to Risk Management

Ongoing risk management is a key component of Exchange planning, establishment, and operations. The effectiveness of risk management requires the engagement and active participation of Exchange leaders and team members. The Exchange team regularly incorporates risk analysis into status and planning meetings and works together to identify risks and execute appropriate mitigation plans. Identified risks are brought to the attention of the state Project Manager and are discussed during semi-monthly project status meetings, as is progress made towards executing risk mitigation plans as appropriate. A more formal risk management strategy will be developed when a Project Management Office (PMO) is established (see section 9.2.1), and the PMO will bear responsibility for monitoring and managing overall project risks that impact all projects within the program portfolio, as well as for working with individual project managers to monitor and mitigate risks and issues specific to each project.

The following template is used for logging and tracking risks.

#	Risk Definition	Probability[11]	Impact[12]	Approach[13]	Risk Mitigation Strategy	Owner	Update

[11]Probability is the likelihood that the risk will occur and is assigned a high, medium, or low rating.
[12]Impact is the effect the risk will have on the Exchange and is assigned a high, medium, or low rating.
[13]Approach is the path taken in regards to the risk and is assigned the status of accept, mitigate, or defer until a later time.

7.0 Communication and Outreach Strategy

A well-conceived communication and outreach strategy that involves developing strong relationships with stakeholders and creating high awareness and acceptance amongst consumers is essential for the success of the Exchange. West Virginia recognizes the critical nature of building an Exchange that focuses on the needs of individuals and small businesses, as well as creating an environment that is desirable for insurance carriers, providers, and brokers. Leaders are committed to designing effective community and stakeholder communications, public education, outreach and marketing activities to secure and maintain Exchange enrollment at levels that support sustainability. Exchange planners have been building communications and awareness throughout the planning process and will continue to do so as the state moves through the planning, establishment, and operations phases of the Exchange.

7.1 Stakeholder Engagement Plan

To maximize public input in the early stages of Exchange planning, a formal request for comment on specific Exchange-related provisions was released in late 2010, and valuable responses from a wide range of stakeholders were received. Comments have been and will continue to be used to inform Exchange planning, establishment, and operations. Responses are available at www.bewv.com.

With the assistance of West Virginia University Center for Entrepreneurial Studies and Development, Inc. (WVU CESD), the Exchange planning team also held a series of well-attended public information and engagement meetings across the state throughout the fall of 2010, which were funded through the SHAP Grant. In 2012, two more rounds of statewide stakeholder meetings (six meetings per round) will be held in 12 different locations to ensure maximum regional coverage; the meetings will be funded through the Level One Establishment Grant. These meetings are designed to provide stakeholders an update on the Exchange planning process, particularly members of the public who are not traditionally involved in the policy-making process.

Exchange planning staff has continued to meet with several stakeholder groups on a monthly basis since the fall of 2010 and will do so throughout the phases of Exchange development to facilitate ongoing involvement and transparency. Separate monthly meetings are held for the following stakeholder groups: small businesses, consumer advocates, producers, providers, and carriers.

7.2 Communications Plan

The hurdles associated with launching the Exchange in West Virginia became clear during focus group sessions conducted around the state during the first quarter of 2011. After the sessions, it became apparent that increased awareness, comfort, and trust about federal health reform and the Health Benefit Exchange would take extra effort and a unique approach in order to reach the diverse population of West Virginia. It also became clear that an extensive marketing, advertising, education and outreach strategy would be necessary to prepare consumers of all populations to be familiar with and able to understand and use the Exchange.

To that end, The Arnold Agency, an advertising and public relations agency, was selected through a piggyback contract (West Virginia Code §5A-3-19) with DHHR to assist in the development of a multi-year, multi-phase communications and marketing strategy stretching from the mid-2012 through December 2014. Ongoing refinement and implementation of the communications plan was transitioned to OIC Health Policy staff in December 2011. Although the strategy is still in the review and approval process, a high-level overview of the paid public information and education campaign is provided below and will be updated as the plan is finalized.

7.2.1 Objectives for Communications Plan

The campaign is focused on meeting the following specific media objectives:

- Reach as many West Virginians as possible, as often as possible;
- Access West Virginia consumers and business leaders at every point of contact and in various media;
- Build awareness for the Exchange brand and acceptance that it is the place to shop for and purchase health insurance for you, your family, or your employees;
- Communicate the benefits and positive attributes of using the Exchange to learn about and purchase the right health insurance coverage; and,
- Overcome perceived negatives and build a positive image for the Exchange by reaching West Virginia consumers and business leaders.

7.2.2 Target Audience for Communications Plan

The target audiences for the media campaign are:

- West Virginia consumers;
- Owners and managers of West Virginia's small businesses; and,
- Community leaders, influencers, and healthcare providers.

7.2.3 Multi-Phase Campaign Strategy

To address issues identified during preliminary research and to introduce and promote a newly developed brand for West Virginia's Health Benefit Exchange, a multi-phase strategy involving five "Be Better" campaign phases is proposed:

- Phase I: Blast & Basics – Be Excited and Curious;
- Phase II: Buzz & Build-Up – Be Informed;
- Phase III: Countdown to Buy – Be Ready;
- Phase IV: Buy, Buy, Buy – Be Insured; and,
- Phase V: Buy, Prove, Promote – Be Reassured.

Each phase will use a carefully crafted media strategy to reach the Exchange's wide array of target audiences. In addition, the creative messages used during each phase will be tailored to meet a specific purpose. Along the way, message and media usage will be monitored using sophisticated research methods to ensure effective exposure and attitudes, behaviors and beliefs of the public toward the Exchange. Please see the table below for a summary of the five proposed phases of the media campaign.

Table 8: Health Benefit Exchange Media Campaign Phase Summary

Phase	Timeframe	Goals and Strategies	Key Messages
Planning Phase	January 2012-June 2012	• Establish Exchange's marketing/PR infrastructure • Identify and negotiate preferred partner relationships • Address web site issues • Conduct research to ID target markets and groups • Develop message • Develop brand	NA
Phase I: Blast & Basics	TBD	• Short duration • Strong saturation • Build curiosity • Introduce brand • Community events • Collaborative agreements with state universities	"Be Excited and Curious."
Phase II: Buzz & Build-Up	August 2012 – March 2013	• Longest pre-launch phase • Information and education heavy • Raise awareness • Build demand	"Be Informed."
Phase III: Countdown to Buy	April 2013 – February 2014	• Brand heavy • Countdown to launch • "Buy here. Buy now."	"Be Ready."
Phase IV: Buy-Buy-Buy Total	June 2013 – February 2014	• Evolution of Countdown message • Solid sales call-to-action	"Be Insured."
Phase V: Buy-Prove-Promote	December 2013 - December 2014	• Continue sales call-to-action • Bring in success stories • Show economic impact	"Be Reassured."

7.3 Other Communications and Outreach Efforts

7.3.1 Small Business Community

West Virginia has opted to place the SHOP and individual Exchange under the same Board and administrative parameters for the purpose of streamlining decision-making and sharing costs, and therefore Exchange planning, establishment, and operations for small businesses will have many synergies with overall Exchange planning. However, it is essential that specific communication and outreach occur to ensure the business community understands the basics of the Exchange, its direct impact on them, and the options available to them under the ACA. Open dialogue will also ensure that Exchange design and policies meet the unique needs of West Virginia's small employers, ultimately facilitating their buy-in and participation in the Exchange and expanding health insurance coverage to their employees.

In addition to the aforementioned monthly small business stakeholder meetings, communication and outreach efforts to date include the development of an outreach and education plan designed specifically for employers and employees. The plan, which was shared with the small business community, outlines education, promotion, and outreach goals and the communication tools that will be used to achieve those goals. Working with the Arnold Agency, the original outreach and education plan for the small business community will be updated and

implemented throughout the planning, establishment, and operations phases of the SHOP Exchange.

Last, as provided for in the Level One Establishment Grant, plans exist to hire a SHOP Advisor/Business Community Liaison consultant to work directly with multiple associations and members of the business community, ensuring their concerns are addressed in the policy and technical design of the Exchange. This position will be filled when the Board is in place and after core Exchange personnel, such as the SHOP Manager, are hired.

7.3.2 Website

The West Virginia Health Benefit Exchange website, www.bewv.com, launched in late June of 2011. Although the initial site design and functionality is very basic, it allowed information about the Exchange to move from the OIC state site to its own designated site and provided additional functionality not available on the state site. In this initial phase, the website is a housing location of information, serving as a resource for the public and other interested parties concerning the planning and development of Exchange policies.

The second phase of the website development, which will launch in 2012, will return to an HTML format, allowing for a higher level of sophistication and reassuring the citizens of West Virginia that the state has the ability to maintain and manage the future complex Exchange website. Health Policy Staff are preparing an RFP to secure a vendor to continue work on the site. Although it remains undecided, consideration will be given to using bewv.com as the Exchange web portal to capitalize on existing domain name familiarity with consumers.

7.3.3 Community of Interest Exchange Policy Groups

To maximize community and stakeholder input into the development of Exchange operations and policies, a recommendation will be made to the Board when it is in place to allow for the creation of Community of Interest Exchange Policy Groups around four categories: Access and Outreach, Plan Development and Assessment, Budget and Finance, and Operations. Subgroups will be formed based on interest in those categories in order to dig deeper into the various policy options available to the Exchange. These subgroups will have designated members but will also allow for those interested to self-select in participation so as to not preclude an interested party from a group for which they feel they have valuable input. Until the Board is in place and these groups can commence, Exchange planning staff will develop a more defined strategy regarding how to manage the groups including their composition, purpose, authority, and relation to other groups such as workgroups and to expedite the launch of the workgroups when the Board is seated. A consultant, WVU CESD, will provide facilitation services for these groups, including ensuring that meeting locations are secured and safe; taking notes and placing those notes onto the Exchange planning website; managing discussions amongst stakeholders; and ensuring that all discussion points are relayed to the Exchange Board. Level One Establishment Grant funding has been secured to cover costs associated with these meetings, and additional funds will be requested in the Level Two Establishment Grant to provide for meetings through 2014.

7.3.4 Health Coverage and Healthcare Literacy Study

Illiteracy can create a large obstacle to developing tools to ensure an educated consumer for health coverage and health care. Consequently, funding for a study to contemplate lessons learned from enrollment in the SHAP Demonstration for the Uninsured, Medicaid and CHIP, as well as to review the output of materials developed by multiple stakeholders at the NAIC on simplifying health insurance terms for consumers, was received through the Level One

Establishment Grant. The study will also investigate how low literacy impacts a consumer's ability to follow a physician's directions and how this correlates with continued poor health and failure to treat costly chronic conditions. A contractor will be selected to work with multiple stakeholders to develop strategies on how to best reach low literacy and linguistically unique rural populations to expand the number of consumers that understand and procure coverage but also understand how to follow physician directions to improve the overall risk pool through better health management.

8.0 Operations Plan

As of late 2011, key operational decisions for Exchange functions remain open until critical information to guide the decision-making process is known and until a Board and Executive Director are in place to advise the process. Important information was gathered in November 2011 by eliciting vendor perspectives on cost, methodology, staffing, and technical design of the various Exchange functional/programmatic components through a request for information (RFI). RFI responses are being summarized, reviewed, and mined for key information in December 2011 and January 2012. In addition, an RFP for a contractor to perform actuarial analysis and economic modeling with cost estimates for each of the following items is planned:

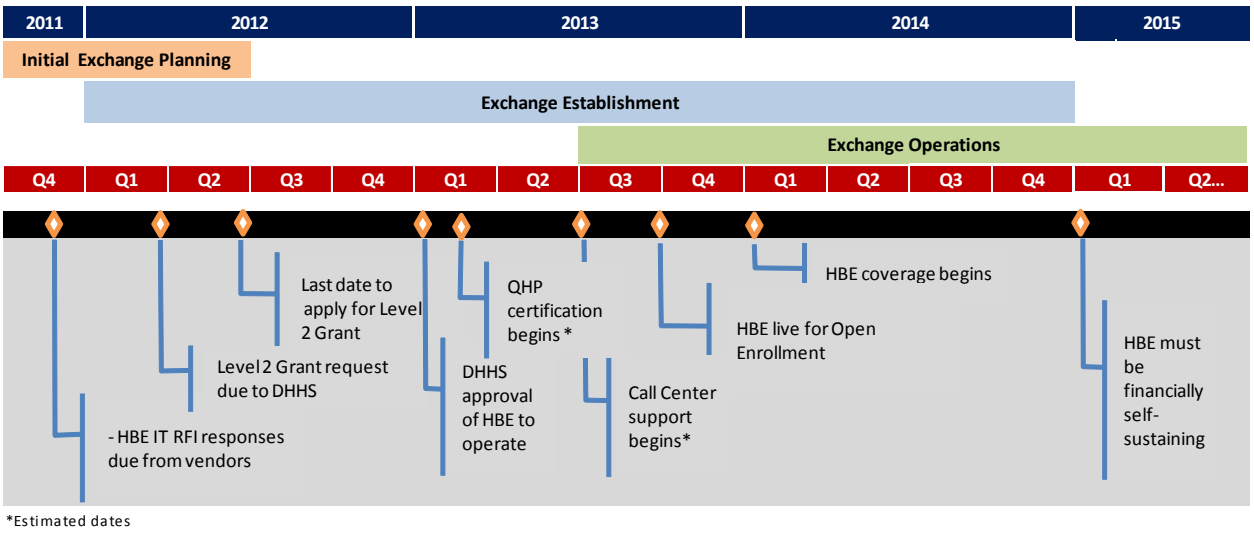
- Partnerships and contracting needs to support the Exchange, including the costs associated with an external toll-free consumer hotline and Navigator program;
- Financial, accounting, federal and state reporting, and legal services (including the cost of reconciling tax credits and cost-sharing subsidies for employers and individuals in partnership with the federal government); and,
- Any other fundamental operating expenses associated with carrying out the mandatory functions of an Exchange, as described in the ACA.

The contractor selected to perform the actuarial analysis and economic modeling will also project the cost to run an Exchange for the first three years of operations beginning January 1, 2014, using estimates for enrollment and participation that are also developed by the contractor. The analysis will provide suggested staffing needs and capabilities, as well as proposed methodologies for generating funds to support operation of the Exchange and its related services. The estimates will leverage, integrate, and consider existing state resources to the greatest extent possible and will be based on actuarial and economic modeling to ensure the state clearly understands the assumptions and true impact of an Exchange on its existing revenues and state budget, market rules, and current market structure.

Although Exchange planners await this information and a functioning Board to make key decisions, high-level information about business operations based on federal laws, regulations, and guidance, as well as from other states' planning efforts and West Virginia's Exchange IT Strategic Plan, is available and therefore planning efforts continue. An overview of decisions and plans to date is provided in the following sections of the operations plan. As Exchange planning and establishment efforts – such as the creation of a master project work plan and supporting workgroups – continue and as operational decisions are made, this section of the business plan will be updated accordingly.

Please see Figure 3 below for a high-level timeline of the Exchange planning, establishment, and operations.

Figure 3: Exchange Implementation Phases and High-Level Milestones



8.1 Business Operations

The business operations of the Exchange, as we know them at this point in time, are described by the six core business areas and their key business functions outlined in the CMS Exchange Reference Architecture (ERA): Foundation Guidance v0.99 March 16, 2011, plus the Exchange requirements and functions set forth in the ACA and the Notice of Proposed Rulemaking (NPRM) 45 CFR Parts 155 and 156, Establishment of Exchanges and Qualified Health Plans. The six main business areas and their associated functions are outlined below in Table 9. In addition to these areas, general administrative functions will be required to support Exchange operations, as will SHOP-specific functions. As planning and establishment progresses through the work of the core Exchange team, workgroups, and others such as IT and Systems Integrator vendors when they are selected, process mapping will be completed for each business area and its associated functions. Mapping will include who is responsible for each process, what major functions are performed in the process, and when each function in the process is triggered.

Table 9: Exchange Business Operations and Functions

Business Operations	Proposed Rules	Functions
Eligibility and Enrollment	45 CFR 155.200 (b)	Determine eligibility for exemption from the individual responsibility requirement
	45 CFR 155.200 I	Determine eligibility for advance premium tax credits, cost-sharing reductions, Medicaid and CHIP
	45 CFR 155.200 (d)	Manage appeals of individual eligibility
	45 CFR 155.400	Enroll qualified individuals into qualified health plans

Business Operations	Proposed Rules	Functions
		(QHPs)
	45 CFR 155.405 (a)	Provide a single streamlined application for QHPs, advance payments of the premium tax credit, cost-sharing reductions, Medicaid, and CHIP
	45 CFR 155.205 I	Provide a premium calculator
	45 CFR 155.405 I(2)	Provide the tools to allow for applicant to file an application via an Internet portal; by telephone through a call center; by mail; and in person
Plan Management	45 CFR 155 Subpart K	Provide plan certification, recertification, and decertification; plan monitoring and review
	TBD	Provide plan quality rating
Financial Management	45 CFR Part 153	Perform plan assessment, reinsurance, risk adjustment, and risk corridor functions
	TBD	Reconcile reductions in enrollee out-of-pocket costs
	TBD	Determine issuer credits
	TBD	Administer premium tax credit and cost-sharing reduction
Customer Service	45 CFR 155.205 (a)	Provide a call center
	45 CFR 155.205 (b)	Establish an Internet Website
	45 CFR 155.205 (d)	Assist consumers, including the Navigator program
Communications	45 CFR 155.205 (e)	Perform outreach and education
		Provide applications and notices
		Measure/report communication effectiveness
Oversight	45 CFR 155.200 (e)	Provide oversight and ensure financial integrity
	45 CFR 155.200 (f)	Oversee quality activities

8.2 Physical Location, Facilities, and Equipment

8.2.1 Physical Location and Facilities

State staff and contractors for Exchange planning and establishment activities and ongoing general administrative operations will be housed within the existing OIC Health Policy offices and the offices of other OIC divisions such as Administrative Services and Rates and Forms at the Greenbrooke Building on 1124 Smith Street in Charleston. Level One Establishment Grant funding will support expenses for facility costs through June 2012 including rent, utilities, telephone, janitorial, and other operational costs. Additional office space next to the Health Policy offices has been requested; the space has been physically cleared but approval to expand into it has not been granted. Physical space requirements for additional Exchange operations, such as the call center, are not known as key decisions including whether or not to contract externally for these services have not been made. Physical location plans will be updated as Exchange design decisions are finalized. Level Two Establishment Grant funding will be requested to support facility costs through the end of 2014, at which time Exchange revenues will be used.

8.2.2 Equipment

Additional equipment and supplies are required to support all Exchange stages from planning through operations. Level One Establishment Grant funding for start-up needs including computers, workstations, and smart phones for eight new Exchange employees and general office, printing, and mailing supplies was secured. As specific needs for equipment and supplies to support ongoing Exchange planning, establishment, and operations are identified, Level Two Establishment Grant funding will be requested through the end of 2014 to cover the expenses, after which time Exchange revenues will be used. General equipment and supplies will be procured via the existing process of submitting requests to the Purchasing Division in the OIC Department of Administration; the exemption process, as provided for in Senate Bill 408, will be leveraged as needed for large equipment purchases.

8.2.3 Information Systems

In mid-2011 a management consulting firm, BerryDunn, was competitively procured to develop an IT Strategic Plan for the Exchange to assist the state's executive decision-makers prepare for the future by defining the action steps necessary to meet Exchange IT goals, business and system needs, and program priorities. The plan provides important input for future Exchange funding requests and is a key component of an RFP for Exchange systems integration, hardware and software. Based on a review of over thirty state IT assets, collection of information from over sixty individuals in state government and the private sector, interviews with five Early Innovator grantees, and a comprehensive review of federal laws, regulations and guidance issued to date, the Exchange IT Strategic Plan provided the state with a review of the current environment for West Virginia's Exchange, a gap analysis, a list of strategic IT issues, a list of recommended strategic IT initiatives to address gaps and issues, Exchange IT cost considerations, and Exchange IT design options.

The Exchange IT Strategic Plan identified nine state IT assets that could potentially be leveraged in the future Exchange IT environment. The assets providing the best opportunity for re-use are RAPIDS, the existing integrated eligibility and benefits issuance system for programs including Medicaid and CHIP; inROADS, the public-facing self-service portal for applying for, renewing and managing those state benefit programs; and SERFF, the System for Electronic Rates and Forms Filing. Additionally, eleven technical gaps and twelve functional gaps between the current and future required IT environments were identified, as were 25 critical strategic IT

issues and eight strategic IT initiatives to address the gaps and strategic IT issues. Finally, four Exchange IT design approaches were developed for the future Exchange environment including:

- Existing state IT assets drive the Exchange IT design;
- Newly-procured IT assets drive the Exchange IT design;
- Partnerships with other states to procure shared IT assets drive the Exchange IT design; and,
- A State-Federal Partnership or Federally-facilitated Exchange drives the Exchange IT design.

In addition, special consideration was given to SHOP-specific IT requirements. Unique Exchange website functionality to support the SHOP may include: special user interfaces allowing small businesses and their employees to complete employer and employee applications; producer access to facilitate employer/employee enrollment; and the ability to display coverage options selected by employers for their employees and the employees' cost of plans after employer contributions are applied. Premium billing and collections will also be more complex for SHOP Exchange customers than for individual consumers, necessitating a system capable of aggregating employer payments, reporting amounts due to multiple carriers, bundling payments by carrier across multiple employers, and reconciling payments due carriers across multiple employers. The Exchange may also choose to provide specialized attention for small businesses through its call center, which may include the availability of a separate toll-free number.

The findings of the IT Strategic Plan were shared with other stakeholders for feedback, discussion, and decision-making purposes in November and December 2011 by the Exchange planning team and BerryDunn. In partnership with other state agencies such as DHHR and the Office of Information Technology, as well as external organizations such as the NAIC, Exchange planners are actively considering their options for IT systems development to support Exchange needs. As information from the RFI for Exchange IT components is reviewed and analyzed, and as IT decisions are made by Exchange leaders, this section of the operations plan will be updated.

8.3 Other Supporting Functions

8.3.1 Evaluation

Evaluative tools to measure the successes and shortcomings of Exchange policies and operations will be developed, with particular focus on the financial impact of the Exchange on consumers and the market, as well as changes in population health. Special attention will be paid to find strategies that incorporate measures that are easily accessible and understood by the public. Discussions with the State Health Access Data Assistance Center (SHADAC), a state-affiliated agency with whom the Exchange will partner to develop the evaluation plan, have commenced and will continue throughout Exchange implementation and operations. Initial funding for plan development was secured by the Level One Establishment Grant, and additional funds will be requested in the Level Two Establishment Grant as needed.

8.3.2 Financial Management

As the Exchange in West Virginia is housed in an existing state agency, the structure of the financial management of the Exchange will be incorporated into the existing accounting and auditing structures of the OIC. The Exchange adheres to all DHHS financial monitoring activities

carried out under the Establishment Cooperative Agreement and as carried out for the Planning Grant. These procedures include, but are not limited to:

- Comply with applicable Office of Management and Budget (OMB) Circulars;
- Comply with requirements to complete quarterly Federal Cash Transaction Reports in the Payment Management System;
- Complete all drawdowns in compliance with federal regulation;
- Complete regular internal audits on federal funds;
- Complete the reporting process in a timely manner;
- Comply with all state regulations existing for Accounts Payable, Budget, and Treasury;
- Adhere strictly to the guidelines set forth in grants; and,
- Comply with state and federal guidelines in completing the SEFA (Schedule of Expenditures of Federal Awards) at fiscal year-end.

The state of West Virginia has substantial statutory and regulatory requirements in place to ensure appropriate financial management of all federal grants received by the state for the Exchange. Other milestones related to financial management are: to launch a budget and finance community of interest group when the Board is appointed in order to develop a team and increase financial effectiveness; define a financial management structure to adhere to Government Accountability Office auditing to ensure compliance with state and federal regulations; and to select an auditing firm to assess system of internal controls to ensure fair and appropriate vendor selection.

In addition, a special interest-bearing revenue account in the State Treasury, called the "West Virginia Health Benefits Exchange Fund", will be administered by the Board and used to pay all costs incurred in implementing the provisions of the Bill.

9.0 Staffing/Resource Plan

This section describes the proposed resources required to execute the three major phases of Exchange implementation:

- Phase I: Initial Exchange Planning (in progress);
- Phase II: Exchange Establishment (commences once the Board is appointed); and
- Phase III: Exchange Operations (commences when advertising for open enrollment begins and the Call Center needs to be live, estimated summer 2013).

Both primary and supporting resources are necessary during all three phases, consisting of Exchange staff, staff from other agencies and entities, vendors and consultants, and multi-stakeholder workgroups. Primary resources have decision-making authority and form the core team with the responsibility and accountability for ensuring critical Exchange tasks are completed. Supporting resources supplement and/or augment the core team primary resources with subject matter expertise, stakeholder representation, and other specialized skills.

Table 10: Exchange Resource Requirements by Phase

Phase	Primary Resources	Supporting Resources
Initial Exchange Planning	• OIC Staff	• OIC Staff • Vendors and Consultants
Exchange Establishment	• Exchange Staff • Vendors and Consultants	• OIC and Other State Agency and Entity Staff • Vendors and Consultants • Workgroups
Exchange Operations	• Exchange Staff • Vendors and Consultants	• OIC and Other State Agency and Entity Staff • Vendors and Consultants • Workgroups

The number and source of Exchange resources required will evolve as the Exchange moves through the planning and establishment phases and transitions to the operations phase. As Senate Bill 408 establishes the Exchange within the OIC, OIC staff has been performing initial Exchange planning tasks and the OIC Commissioner serves as the executive decision-maker until the appointment of the Exchange Board. During the establishment phase, Exchange staff and contractors will be hired to continue the planning, design, development, and implementation efforts. During the operations phase, resource requirements will change again, and resource planning for this phase will occur during the establishment phase.

This section describes Exchange resource requirements by phase and when known, their roles and responsibilities. In addition, this section lays out the approach to staff training.

9.1 Initial Exchange Planning Resources

Personnel from the OIC Health Policy Division have been leveraged to support the initial planning phase of the Exchange. Four positions from the Health Policy Division are dedicated to the Exchange full-time: the Project Director, Lead Economic Researcher, Insurance Program

Specialist for Outreach, and Secretary. One position, the Health Policy Director, is partially dedicated to the Exchange, and two government interns also assisted in the early planning phase. In addition, the OIC Information Technology Division has provided an IT Lead for the Exchange. The OIC Commissioner serves as the chief state executive representing the Exchange. As of late 2011, all of the staff positions were filled except the Secretary. These resources will continue to support the Exchange planning until additional resources are hired and/or procured.

This OIC Health Policy Exchange team is supported on an as-needed basis by personnel from other OIC divisions including Legal, Rates and Forms, and Market Conduct, and other state agencies such as a Project Manager from the Office of Technology. A competitively-procured vendor assisted the OIC team with development of an IT Strategic Plan and provides ongoing project management support, and a communications and marketing vendor is in place to support initial Exchange planning. An actuarial analysis and economic modeling contractor has not yet been selected and Medicaid/CHIP/Other State Agency Liaison positions remain unfilled.

The table below describes the roles and responsibilities of the key resources involved in the initial Exchange planning phase.

Table 11: Initial Exchange Planning Phase Required Resources

Position	FTEs/ Hours	Source	Roles and Responsibilities
Primary Resources			
Chief Executive	N/A	OIC Commissioner	• Represent the Exchange in discussions with the Governor's Office and State Legislature. • Represent the Exchange in discussions with other state agency and entity executives. • Serve as executive decision-maker and approving authority for grant applications, contracts, and other legally-binding agreements.
Project Director	1 FTE	OIC Health Policy Division	• Direct project, coordinate efforts of stakeholder groups, present policy decisions to leadership, and serve as liaison with DHHS. • Serve as lead on Establishment Grants and PEG Grant. • Manage all Exchange staff and contractors and all Exchange research, planning, and development until Executive Director (ED) is hired.
Lead Economic Researcher	1 FTE	OIC Health Policy Division	• Assist in all facets of Exchange research. • Lead research efforts on regional Exchanges; market research on web utilization; producer research; and plan

Position	FTEs/ Hours	Source	Roles and Responsibilities
			standardization research. • Draft research procurements. • Coordinate Exchange research efforts with that of other research institutions and governmental agencies. • Evaluate efforts of program. • Lead quality care research efforts.
Insurance Program Specialist for Outreach	1 FTE	OIC Health Policy Division	• Serve as resource in all program areas. • Responsible for carrying out research in health policy and insurance. • Work with vendors, state agencies, stakeholder groups, and other public and private partners on policy research. • Assist with grant development, grant compliance, and grant budgeting. • Assist with procurement development, processing, and ensuring follow through from vendors. • Undertake special assignments as deemed necessary by the ED and the Board. • Develop education and outreach strategies, particularly with respect to grassroots education and outreach efforts in solidifying public understanding of the Exchange and encouraging consumers to utilize Exchange benefits.
Health Policy Director	.2 FTE	OIC Health Policy Division	• Assist with coordination of overall health insurance reforms and transitioning of existing programs, like AccessWV. • Assist with development and implementation of strategies related to risk adjustment. • Perform other tasks as necessary.
IT Lead	.8 FTE	OIC Information Technology Division	• Oversee IT-related issues between the Exchange and the OIC. • Oversee the development of the IT strategic plan; gap analysis; and review of all federal IT guidance and output from other state Exchanges. • Oversee interfacing efforts with other state agencies and federal government; and, • Work with insurance carriers to ensure maximum efficiency in Exchange-issuer interfaces.

Position	FTEs/ Hours	Source	Roles and Responsibilities
Secretary	1 FTE	OIC Health Policy Division (vacant)	• Act as office manager for the project. • Schedule meetings, copy and fax documents, and perform other necessary administrative duties. • Prepare analytical and statistical reports and documentation necessary for conferences and meetings, both internal and external, transcribes and utilizes the appropriate software to effectively communicate documentation to the necessary parties. • Manage other documentation needed by the Exchange. • Research and analyze inquires from internal and external factions and deliver timely responses.
Health Policy Consultants	2 FTEs	Contract with BerryDunn	• Provide ongoing assistance with all Exchange planning efforts as needed • Perform health policy and insurance reform research • Assist with management of grant funds and development of an Exchange work plan • Coordinate, lead, and prepare materials for internal and external stakeholder meetings
Supporting Resources			
Associate Counsel (2)	.2 and .6 FTEs	OIC Legal Division	• Advise and assist in establishing and interpreting legal policies, statues, and Legislative Rules with respect to the project's programs, policies and procedures. • Review and analyze federal and state laws, regulations and guidance and communicate information to the OIC core team. • Advise the OIC team on procurement. • Develop Board by-laws
Communications	.2 FTE	OIC	• Handle communications for the OIC and serve as liaison with Department of Revenue and Governor's Office.
Communications and Outreach Resources	TBD	Contract with Arnold Agency	• Develop and implement a marketing, advertising, education and outreach strategy including a paid, public education and information campaign and website development. • Coordinate and facilitate a number of

Position	FTEs/ Hours	Source	Roles and Responsibilities
			statewide stakeholder meetings. • Provide speaker training and staff some outreach events.
IT Strategic Planning and Project Management Resources	3,000 hours	Contract with BerryDunn	• Develop Exchange IT Strategic Plan, including gap analysis. • Provide assistance in the development of grant applications and procurement documents (RFI/ RFP) as necessary for Exchange IT needs. • Provide coordination, facilitation services and project management for IT -related work. • Assist in additional ongoing project management as requested.
Actuarial Assessment and Economic Modeling Resources	3,500 hours	Contractor TBD	• Provide overall planning and analysis to support the state in the development, design, and as appropriate, creation of an implementation plan for the Exchange including performing background research, developing and analyzing several Exchange design options, and performing an Exchange organizational and impact assessment.
State Agency Liaison (Medicaid/CHIP and Other State Agency)	1,500 hours	Contract with BerryDunn	• Serve as a liaison on all policy issues related to Medicaid, CHIP and the Exchange. • Ensure that work plans between Medicaid, CHIP and the Exchange remain on schedule. • Serve as a liaison between the Exchange and the Bureau for Children and Families, the Health Care Authority, and other state government entities as needed.

9.2 Exchange Establishment Resources

9.2.1 Primary and Supporting Resources

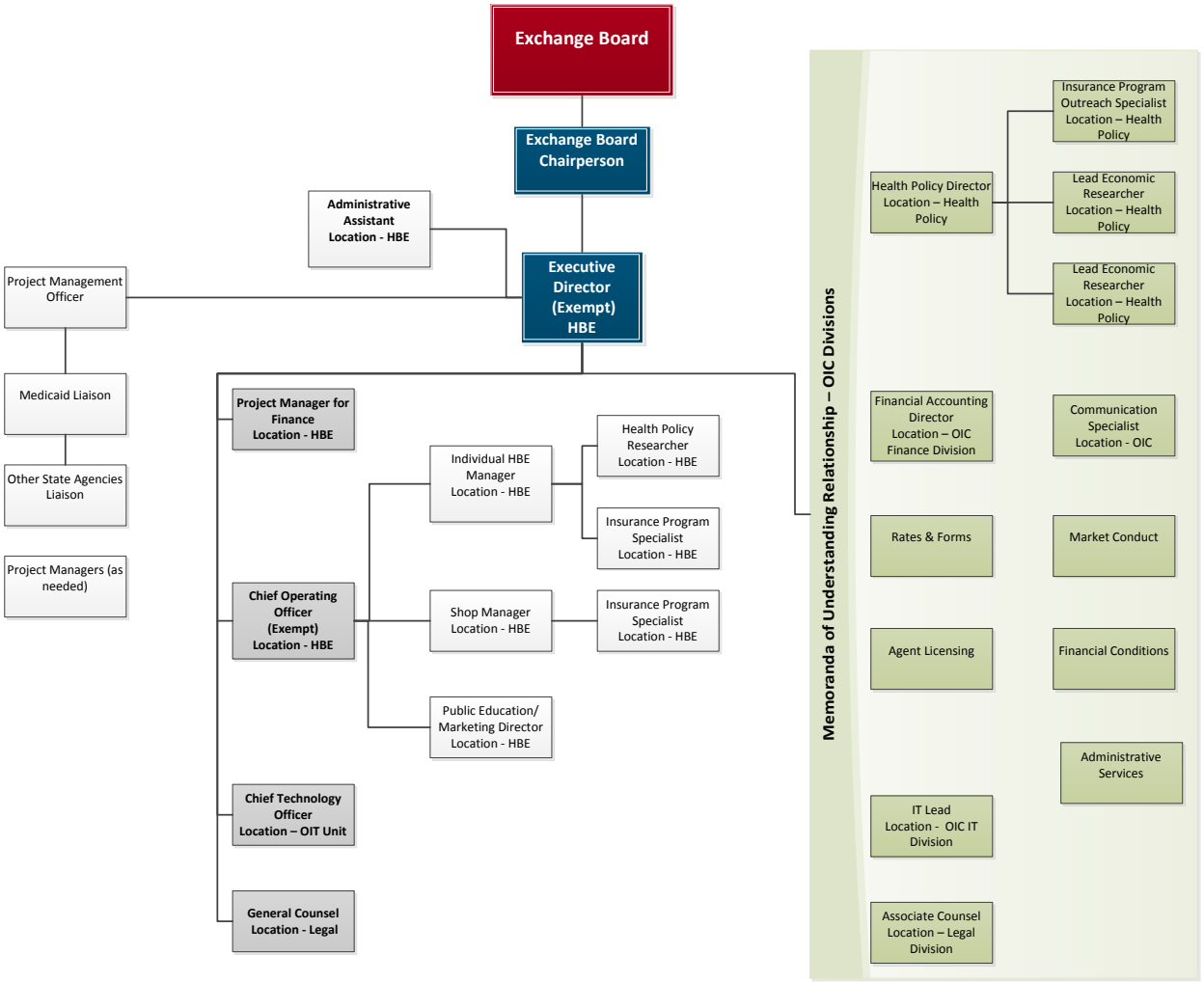
Preliminary planning efforts indicate an Exchange staff of 15 full-time equivalents (FTEs) will be required to establish the Exchange for a one-year period. It identifies the need and provides funding for an executive management team consisting of an Executive Director, Chief Technology Officer, Attorney, Project Manager for Finance, and Chief Operations Officer. It also supports 10 administrative and project staff: an Administrative Assistant, Public Education/Marketing Director, Individual Exchange Manager, SHOP Manager, Project Management Officer, two Insurance Program Specialists, and a Health Policy Researcher. Together, the executive management team and staff will comprise the primary resources responsible for seeing that the minimum functions of an Exchange are implemented according to federal guidance and regulations and the initiatives outlined in the Level One Establishment Grant are executed. A Level Two Establishment Grant will provide the funding for these

positions as needed beyond the initial one-year Level One Establishment Grant period through December 31, 2014.

Senate Bill 408 authorizes the Exchange Board to employ an Executive Director who has overall management responsibility for the Exchange, and additional employees as necessary. Once the Board is in place, the Exchange may exercise the exemption from State Personnel rules provided for in the Bill. Hiring the Executive Director and staffing the Exchange with key management personnel will be a priority once the Exchange Board has been appointed.

The figure below illustrates the staffing plan proposed to support the Exchange establishment phase, and the relationship between the current OIC staff who are in place to support Exchange planning and the projected Exchange staff and contractors who will be hired during this phase.

Figure 4: Exchange Establishment Phase Organizational Structure



During the establishment phase, supporting resources in the form of staff from OIC and other state agencies and entities, vendors and consultants, and workgroups will assist primary

resources to complete critical tasks. Given the short timeline to interview, hire, and train staff to develop the required level of expertise before the Exchange goes live; the fact that many aspects of the Exchange are project-oriented and time-limited in nature and do not require permanent positions; and the desire to create a financially-efficient Exchange, many required resources may be outsourced and memoranda of understanding (MOUs) will be developed with other state agencies to secure resources to perform certain functions to capitalize on existing internal knowledge, skills, and resources.

With the exception of the OIC Commissioner, who will cede chief executive responsibilities to the Exchange Executive Director and move to a position on the Exchange Board; the Project Director position in the Health Policy Division, which may transition into an Exchange position; and the IT Strategic Planning contractor, who has fulfilled the responsibilities for that portion of the contract, all other primary and secondary resources from the Exchange planning phase are expected to continue to support the Exchange establishment phase, although the degree to which support will be needed is yet to be determined. Additional clarity will be provided as the Exchange Board is seated, Exchange staff and contractors are hired, and information on the work required to meet timelines is gathered. The table below describes the primary and secondary resources required in the establishment phase and their roles and responsibilities. To avoid redundancy, the resources from the planning phase in Table 11 above have not been included.

Table 12: Exchange Establishment Phase Required Resources

Position	FTEs /Hours	Source	Roles and Responsibilities
Primary Resources			
Executive Director	1 FTE	Exchange Staff	• Carry out the will of the Exchange Board and the Exchange Board Chair, and policy coordination of the Exchange. • Build collaborative working relationships with diverse groups (e.g., insurance agent associations, insurance payors, medical providers, state and federal agencies, local agencies, small and large businesses, advocacy groups, and consumers) necessary to the development of an Exchange infrastructure that meets the requirements of the Exchange and meet the needs of West Virginians. • Develop an infrastructure to oversee/ coordinate with other stakeholders and provide services and support to the West Virginia Health Benefit Exchange project. • Coordinate with the WVOIC and other state agencies to ensure maximum efficiency in resource utilization; and, • Ensure stakeholder input is communicated and included in planning, development and implementation of the

Position	FTEs /Hours	Source	Roles and Responsibilities
			project.
Chief Operating Officer	1 FTE	Exchange Staff	• Develop business operations as set forth by policymakers; Exchange Board; and OIC. • Develop, strengthen and coordinate a strategic approach to policy development as directed by the ED. • Introduce economic analysis as a routine component of assessment, evaluation and program development activities; and, • Build capacity for program evaluation.
Chief Technology Officer	1 FTE	Office of Technology	• Oversee the development and implementation of the IT systems architecture, network and databases necessary for the infrastructure. • Ensure that the Office of the National Coordinator's (ONC) recommended standards and Systems Development Life Cycle (SDLC) frameworks are adhered to including the use of iterative and incremental development methodologies. • Coordinate and monitor multiple vendors contracted for various technical sections of the project. • Oversee and participate in the gathering, development and analysis of data required to ensure successful results. • Recognize and resolve problems at all phases of development and implementation. • Ensure the interoperability and standardization necessary for systems use by other states • Provide research and project design support and training to other states and agency partners. • Ensure Exchange interface with appropriate federal, state, and private industry systems.
General Counsel	1 FTE	Exchange Staff	• Assist in the development of legal and regulatory strategies. • Provide legal counsel on various federal and state rules/laws as related to health and insurance policy.

Position	FTEs /Hours	Source	Roles and Responsibilities
Project Manager for Finance	1 FTE	Exchange Staff	• Develop and implement the financial model by which the Exchange will become self-sustaining. • Manage financial components of any grants available to the Exchange. • Coordinate the financial management of any payments made from the Exchange Fund, including payments to staff, MOU partners, vendors, or other entities designated through contract to receive payment for work rendered for the Exchange. • Perform technical work involving review and analysis related to the operations and administration of the grant. • Work with grant staff to ensure appropriate classification, payment, problem resolution, tracking and reporting of expenditures. • Perform research and present financial information as requested. • Assist in the tracking and reporting of performance information related to financial program and project evaluation; and, • Work with appropriate state and federal agencies to ensure financial compliance; reimbursements; and specified Exchange financial reporting requirements. • Engage Community of Interest Groups to solicit input into the development of Exchange operations and policies.
Administrative Assistant	1 FTE	Exchange Staff	• Act as office manager for the project. • Schedule meetings, copy and fax documents, and perform other necessary administrative duties. • Prepare analytical and statistical reports and documentation necessary for conferences and meetings, both internal and external, transcribe and utilize the appropriate software to effectively communicate documentation to the necessary parties. • Manage other documentation needed by the Exchange. • Research and analyze inquires from internal and external factions and deliver timely responses.

Position	FTEs /Hours	Source	Roles and Responsibilities
Public Education/ Marketing Director	1 FTE	Exchange Staff	• Coordinate education and outreach efforts. • Assist in training and promotion of Exchange. • Coordinate Exchange message with other health reform campaigns. • Lead all training initiatives, including those for Navigators, producers, DHHR frontline staff, and community leaders. • Engage Community of Interest Groups to solicit input into the development of Exchange operations and policies.
Project Management Officer	1 FTE	Exchange Staff/Contractor	• Create a formal and standardized project management structure, which establishes program-wide policies, processes, and methods to be used consistently on each project. • Serve as source for guidance, documentation, and metrics related to the practices involved in managing and implementing projects within Exchange program. • Manage the overall project work plan for the Exchange program, collect regular updates on the progress of each project within the program, provide an online shared project repository, report on risks and issues for specific projects as well as those impacting the overall Exchange program, and develop effective communication processes to keep vendors, state staff, and key decision makers moving toward consistent, business-focused goals and objectives.
Individual Exchange Manager	1 FTE	Exchange Staff/Contractor	• Focus specifically on the implementation of Exchange functions required to meet the needs of the individual market. • Work with public programs like Medicaid and CHIP to improve public policies around churning between Exchange and public programs and coordinate eligibility and enrollment issues. • Implement the process to review requests for mandate exemptions by individuals. • Work with health plans in the individual market. • Monitor the role of navigators, producers

Position	FTEs /Hours	Source	Roles and Responsibilities
			and others tasked with providing assistance to individual consumers. • Engage Community of Interest Groups to solicit input into the development of Exchange operations and policies.
SHOP Manager	1 FTE	Exchange Staff/Contractor	• Focus specifically on the Small Business Health Options Program (SHOP). • Lead work with small businesses to craft SHOP exchange policies to meet the needs of small businesses. • Explore impact of large groups coming into Exchange market. • Work on specific eligibility and enrollment issues as they relates to the SHOP Exchange. • Work with producers and Navigators to ensure appropriate services are being provided to small group consumers. • Engage Community of Interest Groups to solicit input into the development of Exchange operations and policies.
Health Policy Researcher	1 FTE	Exchange Staff/Contractor	• Assist in all facets of Exchange research. • Lead research efforts on regional Exchanges; market research on web utilization; producer research; and plan standardization research. • Draft research procurements. • Coordinate Exchange research efforts with that of other research institutions and governmental agencies. • Evaluate efforts of program. • Oversee quality care research efforts.
Insurance Program Specialists	2 FTE	Exchange Staff/Contractor	• Responsible for carrying out research in health policy and insurance. • Serve as resource to all program leads. • Work with vendors, state agencies, stakeholder groups, and other public and private partners on policy research. • Undertake special assignments as deemed necessary by the ED and the Board.
Systems Integrator	TBD	Contractor TBD	• Design, develop and implement IT hardware and software necessary to perform minimum Exchange functions.

Position	FTEs /Hours	Source	Roles and Responsibilities
Supporting Resources			
Administrative Services (Personnel and Purchasing)	TBD	MOU with OIC Administrative Services	• Review and approve procurement documents such as RFIs and RFPs. • Post procurement documents. • Assist with personnel hiring process including reviewing and posting job descriptions, interviewing, and orientation.
Agent Licensing	TBD	MOU with OIC Agent Licensing	• Assist with developing requirements and process for Navigator training/certification/licensing and overseeing process.
Communications	.2 FTE	OIC	• Handle communications for the OIC and serve as liaison with Department of Revenue and Governor's Office.
Consumer Services Director	.15 FTE	MOU with OIC Consumer Services Division	• Receive inquiries and complaints from WV citizens regarding problems or concerns they encounter in connection with all health insurance issues, and arrive at informal resolution of those problems through direct contact and advocacy with the insurance company.
Consumer Services Manager	.15 FTE	MOU with Consumer Services Division	• Receive inquiries and complaints from WV citizens regarding problems or concerns they encounter in connection with all health insurance issues, and arrive at informal resolution of those problems through direct contact and advocacy with the insurance company.
Financial Accounting Director	.1 FTE	MOU with OIC Finance Division	• Responsible for the accounting system; develop procedures and negotiate contracts for billing, payroll withholding, insurer remittances, insurer fees Exchange functions. • Works with State Treasurer and Tax Department.
Financial Conditions	TBD	MOU with OIC Financial Conditions	• Assist with determining special licensing and financial monitoring requirements for qualified health plans.
Market Conduct	TBD	MOU with OIC Market Conduct Division	• Assist with developing requirements and process for plan management functions including monitoring and compliance.
Rates and Forms	.15	MOU with OIC Rates	• Review and make a final disposition on

Position	FTEs /Hours	Source	Roles and Responsibilities
Director	FTE	and Forms Division	rate and form filings from insurance carries for all health, filings for the state of West Virginia.
Rates and Forms Analyst	.15 FTE	MOU with OIC Rates and Forms Division	• Assist with review and making a final disposition on rate and form filings from insurance carries for all health filings for the state of West Virginia.
Agent/Navigator/ Income Maintenance Worker Policy Strategic Plan Resources	1,000 hours	Contractor TBD	• Review how producers and navigators will operate within the context of the Exchange including review of similar discussions in other states. • Outline the policy options and implications of policy decisions related to both Navigators and insurance producers. • Work closely with consumer advocates, issuers, producers, other stakeholder groups, and other vendors performing work related to producers and Navigators in this project. • Develop a strategy for continuing education, licensure, and payment methodologies.
Project Management Resources	2,500 hours	Contractor TBD	• Tasked with overall project management for the Exchange. • Update the current Exchange work plan and develop a high level project plan • Ensure that work plan is followed; vendors follow through with scope of works; stakeholder meetings are conducted with appropriate feedback back to stakeholders, etc.
Risk Adjustment Advisor/ Strategist	1,040 hours	Contractor TBD	• Assist in the development of a risk adjustment strategic plan. • Work with issuers and the OIC to develop a risk adjustment Board. • Work with the All Payor Claims Database to ensure appropriate collection and analysis of data. • Work with both the Pre-existing Condition Insurance Plan and AccessWV and the Exchange Board concerning risk adjustment-related Exchange policies are undertaken.
SHOP Advisor/ Business	2,080 hours	Contractor TBD	• Work directly with multiple associations and members of the business

Position	FTEs /Hours	Source	Roles and Responsibilities
Community Liaison			community to ensure their concerns are being addressed in the build-out and policy-making of the Exchange. • Research issues like defined contribution, administrative simplification, employee dumping, tax credit and tax subsidy considerations, and other issues as raised by the business community during stakeholder discussions.

9.2.2 Additional Exchange Establishment Phase Initiatives and Activities

Contracted resources were listed in Table 12 above based on priority and/or because they support a core, minimum required Exchange function (e.g., the Navigator program). Level One Establishment Grant funding was secured for several ancillary initiatives and activities to be performed by contractors based on the following U.S. DHHS Exchange establishment core areas: background research; stakeholder consultation; program integrity; providing assistance to individuals and small businesses, coverage appeals, and complaints ownership; health insurance market reforms; program integration; financial management; governance; Exchange IT systems; and business operations. For a list and supporting narrative of the initiatives and activities, please see the Level One Establishment Grant application at www.bewv.com. The priority of initiatives, and Exchange staff oversight for them, will be evaluated as the project transitions to the establishment phase and will be reflected in the work plan.

9.2.3 Workgroups

Multi-stakeholder workgroups will be established to carry out discrete planning and implementation tasks and provide recommendations to the Board when needed. Workgroups will be facilitated by, and report to, an Exchange Project Manager and will vary in composition based on need but may include external stakeholders, Exchange staff, Exchange contractors, and other state agency staff. To facilitate alignment and coordination, members from each workgroup may also participate in the Community of Interest Policy Groups[14], which are intended to provide input into the development of Exchange operations and policies. In conjunction with the team, the Project Manager will develop a charter defining: team purpose, guiding principles, boundaries/expectations, policy framework; tasks to be completed; goals requiring recommendations; timeline; and resource persons. Meeting frequency will be determined by each workgroup as requirements will vary (e.g., some groups may meet more frequently than others), and within a group, frequency may change as work ebbs and flows. Workgroups for eligibility coordination/Medicaid Integration and SHOP planning are envisioned, however the need for additional workgroups will be determined by Exchange staff and contractors when they are on board and specific tasks requiring completion and recommendations needed are outlined as the work required to be completed should drive workgroup creation and composition. Until that time, with the support of the PMO, Exchange planning staff will develop a list of recommended workgroups and their composition as well as develop a template team charter and other materials to expedite the launch of the workgroups when the Exchange establishment team is in place.

[14]See section 8.3.3 for a description of these groups.

The table below lists workgroups from other states that will be considered in West Virginia's Exchange planning efforts. A Steering Committee comprised of the leads in each workgroup may also be formed to assure coordination of efforts across groups. It is important to note that states' workgroups depend on the status of Exchange planning activities in that state. For example, a legislative workgroup may exist in a state where Exchange legislation has not been passed, but may not be necessary in a state with existing legislation.

Table 13: Other States' Exchange Workgroups

State	Workgroups
Arkansas	Consumers; Healthcare Industry; Information Technology; Outreach; Community; State Agencies
Colorado	Marketing, Enrollment and Outreach Workgroup (MEOW); Eligibility, Verification and Enrollment Workgroup (EVE); Small Employer Workgroup (SEWG); Data Advisory Workgroup (DAWG)
Idaho	Governance/Legal/Legislative; Navigators; Medicaid Integration; Information Technology; Funding/Financial; Business Operations; Consumer Outreach/Education/Information; Insurance Market Issues
Kansas	Governance/Legal/Legislative; Agents/Brokers/Navigators; Medicaid Integration and Interagency Communications; Funding/Financial; Business Operations; Consumer Outreach/Education/Information; Insurance Market Issues; Background Research
Wisconsin	Screening and Eligibility; Employer Management; Plan Management, Customer Support; Program Integrity and Verification

9.3 Exchange Operations Resources

The resources required for the operations phase will be determined by the Exchange staff during the establishment phase; requirements will be based on Exchange enrollment projections and decisions about which Exchange functions to perform internally versus outsource. It is expected that the primary resources required during the establishment phase will continue to be required during the operations phase, as well as several of the supporting resources. A Level Two Establishment Grant will be obtained to fund these positions for the first year of operations, and funding for staff in subsequent operations after 2014 will be dependent upon Exchange revenues.

9.4 Staff Development

9.4.1 General Orientation

To Be Developed: An orientation will be provided to all new staff that joins the Exchange team. Although the Exchange's orientation will be developed by staff in the Exchange planning phase, in concert with the OIC's Administration Services Department, an example of an orientation plan from the Washington Health Care Authority (HCA) is provided below. The orientation will review the following content, which will evolve as the project shifts from establishment to operations.

General and Administrative

a. OIC and Exchange Overview
b. Project Organizational Chart
c. Project Overview
d. OIC HBE's Timekeeping and Expense
e. Building/Facility Layout

Project Management Processes

f. PMO Overview – functions, roles, responsibilities
g. Status Reporting – tools, templates, and process
h. Issue Management – tools, templates, and process
i. Risk Management – tools, template, and process
j. Document/Deliverable Management – tools, template, and processes
k. Escalation Process

Project Technologies

l. SharePoint Overview and Instruction (basic and advanced)
m. OIC Enterprise Tools for Requirements Management, Risk/Issue Management, etc.

Exchange-Specific Knowledge Areas

n. Rules and Regulations
o. Requirements Gathering and Management Process
p. Stage Gate Review Process and Tools

9.4.2 Job-Specific Training Needs

As each new staff member joins the team, managers will review their staff skill sets against any new roles or responsibilities needed for the job. Each manager and their staff will discuss where additional training might be needed to ensure staff has the necessary skills to execute the activities for each project phase.

To Be Developed: A description of how training occurs will be provided. The emphasis in this section will be on ensuring staff have the appropriate skills to perform their job duties. Career development and personal growth training will be discussed in staff individual development plans. Although the Exchange's job-specific training needs may begin to be developed by staff in the Exchange planning phase, it is likely it will be completed by the initial Exchange establishment team when they are hired, in concert with existing OIC staff. An example of a training plan layout from the Washington HCA is provided below.

ID	Position	Potential Training Need	Source/Approach
1.	IT Project Manager	• Overview of tools, processes, etc. used by PMO staff • Overview of state IT systems	• Presentation/Meeting • On-the-job • Coaching
2.	Deputy IT Project Manager	• Overview of tools, processes, etc. used by PMO staff • Overview of state IT systems	• Presentation/Meeting • On-the-job • Coaching
3.	PMO Manager	• Overview of tools, processes, etc. used by PMO staff • Additional items listed by PMO role	• Presentation/Meeting • On-the-job • Coaching
4.	Change Management Lead	• Project Branding Guidelines • Existing project training and change capabilities • Existing HCA training programs and capabilities • HCA project communication	• On-the-Job • Mentoring

ID	Position	Potential Training Need	Source/Approach
		methods • Internal guidelines for communication (do's and don'ts)	

9.4.3 Training Schedule

To Be Developed: A schedule of training activities will be provided, which may or may not include actual course information. The required tasks will be shown in chronological order, with beginning and ending dates of each task, the key person(s) responsible for the task, dependencies, and milestones. Tables and/or graphics may be used to present the schedule. Although the Exchange's training schedule may begin to be developed by staff in the Exchange planning phase, it is likely it will be completed by the initial Exchange establishment team when they are hired, in concert with existing OIC staff.

10.0 Budget, Financing, and Sustainability

Exchange policy, operations, and financing decisions are tightly interconnected and overlapping. Important analyses and information-gathering to guide continued planning and decision-making, such as an actuarial analysis to project Exchange enrollment and provide other baseline research and economic modeling, remain outstanding and are expected to be completed in early 2012. Twelve vendors responded to a request for information for Exchange IT components in November 2011, and results are being reviewed, summarized, and mined for key information to assist with Exchange design and cost projections in December 2011 and January 2012. A detailed budget will be developed when more clarity about the set of factors unique to West Virginia's Exchange is gained, such as: membership projections, premium totals for plans sold within the Exchange, IT systems development costs, and ongoing operations costs. In the interim, a template of a summary budget encompassing two years of Exchange planning and establishment (2012 and 2013[15]) and three years of operations (2014-2016) and a description of key components by line item is provided below.

Table 14: Exchange Establishment and Operations Summary Budget Template

Health Benefit Exchange						
Five -Year Projection Budget						
Summary						
Line Item		**Planning/Establishment**		**Operations**		
		2012	**2013**	**2014**	**2015**	**2016**
1	**Membership**					
2	**Member Months**					
3	**Total Premiums**					
	Revenues/Funding					
4	Fees on QHP Premiums					
5	Medicaid/CHIP Allocation					
6	Other Revenues					
7	Federal Grants					
8	**Total Revenues**					
	Expenses					
9	General Administration					
10	Eligibility and Enrollment					
11	Call Center					
12	Premium Billing Engine					
13	Plan Management					
14	IT and Website Design					
15	Appeals Program					

[15]Although it is recognized that some Exchange operations will begin in mid- to late 2013, for the purposes of the budget it is considered an establishment year as the majority of costs in it will be related to those activities.

Health Benefit Exchange						
Five -Year Projection Budget						
Summary						
Line Item		**Planning/Establishment**		**Operations**		
		2012	**2013**	**2014**	**2015**	**2016**
16	Navigator Program					
17	Outreach and Education					
18	Actuarial Services					
19	Auditing Services					
20	Legal and Other Professional Consulting					
21	**Total Expenses**					
22	***PMPM Expenses***					
	Other Non-Operating Revenue					
23	Interest Income					
24	**Total Other Non-Operating Revenue**					
25	**Change In Net Assets**					
26	**Total Net Assets -Fiscal Year Start**					
27	**TOTAL NET ASSETS -FISCAL YEAR END**					

10.1 Membership and Member Months

The budget summary begins with line items for membership projections and member months to convey assumptions used in the determination of the completed budget and to calculate key financial indicators. Membership projections (line item 1) are fundamental to determining revenues and expenses as they drive: 1) estimates of the total premium base (for plans sold within the Exchange) upon which fees may be levied, and 2) variable Exchange costs such as eligibility processing and enrollment, premium billing and collections, and call center functions.

In addition, fixed costs such as management, communications, and IT infrastructure will be distributed across members. Therefore, membership projections and the associated number of member months[16] (line item 2) for the year allow for an understanding of a key financial indicator, the per member per month (PMPM) cost[17] (line item 22) to operate the Exchange on an annual basis. The PMPM cost metric underscores the importance of a robust communications and outreach plan to assure enrollment volumes are sufficient to spread fixed costs and keep administrative fees on a PMPM basis down.[18] To complete these budget items, the contractor hired to perform the actuarial analysis and economic modeling will provide consumer enrollment and Exchange participation scenarios, including estimates of the number and demographic profile of people expected to receive coverage through the Exchange.

[16] Member months are the total number of participants who are members for each month.

[17] PMPM costs are determined by dividing annual operating expenses by member months.

[18] As a benchmark, other states' estimated 2014 PMPM costs are: Delaware -$9.74, Massachusetts -$12.04, North Carolina -$2.77, Illinois -$6.74, Utah -$15.92, Wyoming -$11.46 (Public Consulting Group, 2011). As enrollment increases after 2014, PMPM costs decrease concomitantly.

10.2 Total Premiums and Fees on Qualified Health Plan Premiums

An understanding of total premiums (line item 3), which will be estimated by the contractor hired to perform actuarial analysis and economic modeling, is essential as they serve as the base for administrative revenue after 2014.[19] As authorized in Senate Bill 408, the Board may assess fees (line item 4) on health carriers selling qualified dental or health benefit plans in West Virginia, including health benefit plans sold outside the Exchange. Fees will be based on premium volume of qualified dental plans or health benefit plans sold and will be established in legislative rules. Determination of the fee amount and whether or not to levy fees on plans sold outside of the Exchange will largely be influenced by Exchange operating costs, however Exchange leaders will consider an array of other factors when making these decisions. These factors may include: carrier tolerance level for fees (e.g., what fee, based on percentage of premiums, would be considered "too high"[20]?), inappropriate distortion of the market (e.g., what financial advantages/disadvantages do carriers offering Exchange coverage experience compared with competitors who do not?), and the fairness of assessing fees outside of the Exchange (e.g., should those who do not directly benefit from the Exchange services be assessed a fee on premiums to support Exchange operating costs?). The actuarial contractor will perform an assessment of carrier fees for Exchange participation.

Additional relevant ACA provisions to consider when making these decisions include that insurers must price identical insurance products the same within and outside the Exchange [Section 1301(a)(1)(C)iii],[21] and that if fees are characterized as a state tax, licensing fee or a regulatory fee they can be excluded from the total amount of premium revenue when calculating a carrier's medical loss ratio (MLR), benefiting carriers for purposes of the rebate calculation (42 USC § 300gg-18(a)(3)).

10.3 Medicaid/CHIP Allocation

Depending on joint policy, operational, and technical design decisions between DHHR and the Exchange, the Exchange may incur costs for development of eligibility and enrollment systems used by Medicaid/CHIP members as well as for determining eligibility, enrollment, or providing customer service or other functions for Medicaid and CHIP members when operations begin. In collaboration with DHHR and BCF, the Exchange will allocate costs (line item 5) to those state agencies based on projected Medicaid and CHIP use of Exchange IT services in accordance with federal guidelines including OMB Circular A-87 and subsequent guidance outlining time-limited specific exceptions to these cost allocation requirements for new eligibility systems and enhancements. To inform shared decision-making about cost allocation between the Exchange and DHHR, the contractor performing the actuarial analysis and economic modeling will provide cost allocation estimates between Medicaid, CHIP, and the Exchange.

[19] Although Level Two Establishment Grant funds will be used to support costs in 2014, Exchange leaders may opt to begin assessing fees (if permitted to do so by the federal government) in 2014 to build reserves and provide a source of funding for operations in the early part of 2015.

[20] Oregon estimates its 2014 fee will be 3.3% of premiums, decreasing to 2.8% in 2016 (Oregon Health Policy Board); Illinois estimates its average fee needed to break-even in 2014 and 2015 in aggregate is between 2.42% and 3.75% of premiums, and Massachusetts Connector fees have ranged between 3 to 4%. (Health Management Associates); fees are leveraged on Exchange plans only.

[21] As a result of the provision, levying fees on plans sold only within the Exchange could make it more attractive for carriers to sell identical plans outside of the Exchange as more revenue will be retained; it could also make plans sold outside more price competitive as carriers who do not sell plans in the Exchange could offer the same plan at a lower cost, and carriers who do sell plans in the Exchange could offer similar coverage outside of the Exchange at a lower price. The exclusive availability of federal subsidies through the Exchange may offset these issues.

Most states are in the process of preparing their Exchange budgets and determining their cost allocation formulas, based on actuarial and other data analysis. Two of the Early Innovator states, Wisconsin and Oregon, have shared some of their cost allocation planning information. Wisconsin is estimating a cost allocation of 62% to the Exchange and 38% to Medicaid and CHIP for development of shared IT systems/functionality such as eligibility determination, and 100% of costs allocated to the Exchange for Exchange-only functionality such as the SHOP. For Exchange development activities that benefit Medicaid as well as non-Medicaid populations, Oregon is proposing to allocate 49.7% of costs to Medicaid and 51.3% of costs to the Exchange, based on projected Exchange enrollment. For development activities such as SHOP-specific functionality that benefit a single population group, all costs would be allocated to the Exchange.

10.4 Other Revenues

To determine the total amount of revenues that must be generated to allow the Exchange to be self-sustaining beginning January 1, 2015, the actuarial and economic modeling contractor will develop three-five year annual operating expense estimate scenarios based on the varying policy and design decisions. This analysis will help Exchange leaders understand the administrative revenues required to support Exchange operations on an ongoing basis and to make decisions such as whether or not additional revenue sources (line item 6) may be required to keep fee assessments on carriers within reason. The actuarial and economic modeling contractor will also assess possible sources of additional sustainable funding for an Exchange, including an assessment of likely market impacts from various approaches. Alternative funding sources under consideration by other states include:

- Excise taxes on products or services (including those associates with unhealthy lifestyles such as tobacco);
- Revenue diversion from programs potentially phased out by health reform (e.g., high risk pools, public employee insurance);
- Carrier participation fees;
- Fees on health care providers;
- General revenues;
- Navigator licensing fees;
- Healthcare/wellness advertisers on the Exchange website; and,
- Fees for individual users and/or small businesses.

10.5 Federal Grants

Although the Exchange will depend solely upon administrative revenue to offset operating costs in 2015 and beyond, funding sources (or revenues) from 2012 to 2014 will primarily come from the federal Exchange Establishment Grants (line item 7) from the U.S. DHHS, as provided for in Section 1311 of the ACA.[22] Level One Establishment Grant funds[23] will be used to fund a portion of Exchange planning and establishment costs in 2012, and Exchange planners anticipate requesting Level Two Establishment Grant funds to support the remainder of 2012, 2013, and 2014 expenses by March 31, 2012. The amount of funding to request in the Level Two Establishment Grant will largely be based upon the RFI responses for the Exchange IT and other program components, the actuarial analysis and economic modeling work performed by

[22]The OIC's Rates and Forms Division also received $1 million under an HHS Premium Review Grant, $150,000 of which is allocated for enhancing SERFF and developing an interface with the Exchange to assist with plan management functions.

[23]In July 2011, West Virginia was awarded a one-year Level One Establishment Grant in the amount of $9,667,694.

the contractor, and other states' experiences. If the March 31, 2012 deadline cannot be met for reasons such as the actuarial and economic modeling work is not complete, the grant application will be submitted by the next deadline, June 29, 2012.

Please see Table 15 below for a summary of potential Exchange revenue and funding sources.

Table 15: Potential Exchange Revenue and Funding Sources*

Revenue/Funding Source	Year				
	2012	2013	2014	2015	2016
QHP Fees					
Medicaid/CHIP Allocation					
Other Revenues**					
Federal Grants					

*Cells shaded with diagonal stripes indicate potential source of revenue, i.e., a decision has not yet been made whether or not they will be
**Other revenue sources are described above in Section 11.3.2

10.6 Expenses

Expense estimates (lines 9-20) will be developed based on responses to the RFI for IT and other program components, information from actuarial analysis and economic modeling, research of other states, and policy, technical, and operational design decisions made by Exchange leadership. For the purposes of the summary budget template presented in this business plan, expenses are enumerated by functional/programmatic area; as cost information becomes available, each area will be supported by detailed sub-categories (as appropriate) such as salaries, benefits, contractual goods, contractual services, equipment, and supplies. Alternatively, these sub-categories could be rolled into a summary-level view across functional/programmatic areas (e.g., salaries to support all functions/programs could be presented as a single number in the budget summary).

Based on publicly available information for five other states,[24] start-up costs average approximately $50 million, with a range of $22 million in Arizona to $89 million for a robust model in Illinois. Although some operational costs will be incurred in 2012 and 2013,[25] expenses in these years will largely be comprised of IT systems establishment costs, which, based on other states' estimates, average approximately 76 percent of overall expenses in these start-up years (HTMS). Expenses in 2014-2016 will depend on factors such as enrollment estimates and Exchange policy, technical, and operational design decisions. The actuarial and economic modeling contractor will develop three-five year annual operating expense estimate scenarios based on varying participation scenarios and policy and design decisions, which will be used to inform decision-making by Exchange leaders and for budget development. To provide a ballpark

[24]The five states are Illinois, Arizona, Rhode Island, New Mexico and Kansas. Although the source report authors included West Virginia in their analysis, the numbers used were incorrect and therefore were removed from the average stated in this business plan.
[25]Communications and outreach efforts will occur throughout 2012 and 2013; plan certification will occur in early/mid-2013, and eligibility determination, enrollment, and customer service will begin in October 1, 2013 to support the initial open enrollment period.

range of expected costs, a summary of expected 2014 costs from other states is provided in the table below.

Table 16: State Comparison of Exchange Operating Costs* in 2014

Category	Delaware	Massachusetts	North Carolina	Illinois	Utah	Wyoming
Salary Staff	$1 million	$5.8 million	$6.1 million	$7.3 million	$500,000	$1.3 million
Eligibility and Enrollment	$2 million	$5.5 million	$315,000	$7.2 million	N/A	$1 million
Call Center	$251,000	---	$1.5 million	$9.4 million	N/A	$108,000
Premium Billing Engine	$2.3 million	$9.8 million	$3 million	$4 million	N/A	$225,000
Marketing	$556,000	$1.6 million	$4.8 million	$2.3 million	N/A	$255,000
Navigator	$174,000	$500,000	$2 million	$1.9 million	N/A	$80,000
Actuarial	$201,000	$578,000	$103,000	N/A	N/A	$92,000
Auditing	$32,000	$91,000	$385,000	N/A	N/A	$15,000
Legal/Other Professional Consulting Services	$348,000	$1 million	$3 million	$2.2 million	N/A	$163,000
IT and Website Design	$566,000	$1.6 million	$1 million	$799,000	$302,000	$650,000
General Administrative Costs	$260,000	$747,000	$512,000	$1.1 million	N/A	$269,000
Other	$0	$139,000	$1.1 million	$3.1 million	N/A	$0
Total	**$7.8 million**	**$27.5 million**	**$23.8 million**	**$39.3 million**	**$802,400**	**$4.2 million**
Enrollment	66,443	190,000	714,222	486,000	4,200	30,500
PMPM	$9.74	$12.04	$2.77	$6.74	$15.92	$11.46

*Estimates rounded

Data Source: Public Consulting Group, HBE Project Budget Estimate for Exchange Operations: Wyoming.

10.7 Net Assets

As provided for in the ACA and in Senate Bill 408, the Exchange may generate funds to support its operations and become self-sustaining by January 1, 2015. Although revenues will only be used to fund Exchange operations and not to produce profits, it is reasonable for the Exchange to generate a surplus and create financial reserves to ensure its long-term financial viability, particularly during the first few unpredictable years of operations.

Accordingly, the change in net assets (line item 25) is the difference between total expenses (line item 8) and total revenues (line item 21), plus interest income (line item 23) earned from any assets in the Exchange's special interest-bearing revenue account, the "West Virginia Health Benefits Exchange Fund," as established in Senate Bill 408. Total net assets at year-end (line item 27) equals total net assets at the start of the year (line item 26) plus the increase in net assets.

When the Budget and Finance Community of Interest Policy Group is created and a Project Manager for Finance is hired, other factors to assure sustainability, such as establishing a line of credit for meeting short-term cash flow issues and developing flexibility in vendor contracts if projected enrollment falls short, will be considered.

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